U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 07 June 2007

Case No: 2006-LHC-00749
OWCP No.: 05-119012

In the Matter of:

J.V.,
Claimant,

v.

CERES MARINE TERMINALS/
CERES MARINE TERMINALS, INC.
Employer/Carrier,

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-In-Interest.

Appearances: Ralph Rabinowitz, Esq.
For the Claimant

Lawrence P. Postal, Esq.
For the Employer/Carrier

Before: ALAN L. BERGSTROM
Administrative Law Judge

DECISION AND ORDER – AWARDING BENEFITS IN PART AND DENYING BENEFITS IN PART

This proceeding arises from a claim filed under the provisions of the Longshore and Harbor Workers' Compensation Act, as amended (Act), 33 U.S. Code, Title 33, § 901 et seq., and is governed by the implementing Regulations found in the Code of Federal Regulations, Title 29, Part 18, and Title 20, Chapter VI, Subchapter A .

A formal hearing was held in Newport News, Virginia, on November 13, 2006, at which time the parties were afforded full opportunity to present evidence and argument as provided in the Act and applicable regulations. The Director did not appear. At the hearing, Administrative Law

Judge Exhibits 1 through 10, Claimant[1] Exhibits 1 through 10, 12 through 15-4, and 15-6 through 19, as well as Employer Exhibits 1 through 58, 60 through 63, 65, 67 through 69, and 71 were admitted without objection. (TR at 5, 14, 22, 47, 109.)[2] CX 11 was composed of physical "twist" locks used in securing shipping containers from movement. Since no foundation was laid during the hearing, they were not admitted into evidence. The objection to CX 15-5 was overruled and the documents admitted for the limited purpose of the issue of attorney fees. (TR at 12.) The Employer's counsel withdrew EX 59. (TR at 14.) The objection to EX 64 for lack of foundation (TR 17) was overruled during the testimony of Mr. W. Parker. (TR at 92.) EX 66 was not admitted due to lack of relevance. (TR 18.) EX 70 was admitted over the Claimant's objection. (TR 21.) It is noted that EX 35 and EX 61 were video tape recordings of which only portions were used during cross examination of the Claimant. The post-hearing written briefs filed by the respective counsel for the Claimant and the Employer were also considered.

The findings of fact and conclusions which follow are based upon a complete review of the entire record, in light of argument of the parties, as well as applicable statutory provisions, regulations and pertinent precedent.

STIPULATIONS

The parties have stipulated to, and this Administrative Law Judge finds, the following as fact:[3]

1. The Claimant's right shoulder injury arose out of his employment with Ceres on July 6, 2004.

2. The claim was timely reported and controverted.

3. The average weekly wage at the time of injury was $1,514.55, with a compensation rate of $1,009.70.

4. The Claimant was paid compensation, as reflected by Employer's Exhibit 1, through October 19, 2005.

(JX 1.)

ISSUES

The issues remaining to be resolved are:[4]

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[1] After August 1, 2006, the Department of Labor policy requires the use of initials for claimants' names in the headings and use of a descriptive title in the decision. Accordingly, "Claimant" is used in this decision instead of the proper name of the individual who is the subject of this decision.

[2] The following abbreviations will be used throughout this Decision as citations to the record: JX – Joint Exhibit; ALJX – Administrative Law Judge Exhibits; CX – Claimant Exhibits; EX – Employer Exhibits; and TR – Transcript of Hearing.

[3] Joint Stipulation number 5 was not accepted. (TR at 10.)

[4] At the hearing, the Claimant withdrew his claim of a head injury. (TR at 10.)

1. Whether the Claimant sustained a work-related injury to the cervical spine on July 6, 2004.

2. Whether the Claimant is entitled to permanent total disability compensation from August 17, 2005.

3. Whether the Claimant is entitled to continued medical treatment and reimbursement.

4. Whether, pursuant to § 7(d)(4) of the Act, the Claimant's receipt of compensation benefits and medical services should be terminated as of January 18, 2005.

5. Whether the Employer is entitled to § 8(f) relief under the Act.

(TR at 6-9.)

PARTY CONTENTIONS

Claimant's Contentions (TR 23 to 30, Post-hearing brief)

Claimant's counsel submits that the Claimant sustained right shoulder, head, and cervical injuries when he was hit by a lashing rod on his hard hat and right shoulder near midnight on July 6, 2004, while working as a lasher for the Employer. The Claimant was treated by medical doctors, physical therapists, medication, and injections, and underwent right shoulder surgeries on September 21, 2004, and May 5, 2005. He still takes oxycodone for pain relief. Counsel submits that the Claimant is right-hand dominant with limited range of motion in his right arm, constant right shoulder pain, and depression.

Claimant's counsel submits that the Claimant reached maximum medical improvement on August 18, 2005, when Dr. Wardell assessed the Claimant's right shoulder injury as a 30% permanent impairment of the right upper extremity. He states that Dr. Cohn has assigned a 10% permanent disability rating for the distal clavicle resection and a 7% impairment rating for the decreased right shoulder range of motion. Counsel also argues that the Claimant has been classified as mentally retarded with an IQ of 67 to 72.

Claimant's counsel submits that the Claimant is entitled to permanent total disability benefits, continued medical services, and payment of accrued medical bills.

Employer's Contentions (TR 30 to 37, Post-hearing brief)

Employer's counsel submits that the Claimant has been less than credible with his treating physicians, examining medical personnel, and the Court, and that his self-limiting complaints of pain should not be given any credence. Counsel argues that medical experts have opined the Claimant can work, there is no credible evidence that the Claimant has suffered a covered work-related right shoulder injury resulting in economic loss, and that the Claimant has failed to prove he is disabled under the Act.

Employer's counsel proffers that the Claimant's lack of cooperation at the functional capacity evaluation ("FCE") and misrepresentation of his functional capabilities to medical personnel is sufficient to bar the Claimant from receiving any benefits under the Act pursuant to 33 U.S.C. § 907(d)(4) since January 18, 2005.

Employer's counsel argues that the Claimant is not disabled under the Act and can do light-duty painter's work in the port, general longshore work with twist locks, slinger work, and can drive a hustler. In the alternative, counsel submits that if the Claimant is indeed disabled, the Employer is entitled to § 8(f) relief under the Act.

SUMMARY OF RELEVANT EVIDENCE

Hearing Testimony:

Testimony of Claimant (TR 37 to 87; 120 to 125)

On direct examination, the Claimant testified that he was born on September 22, 1948, and is 58 years old. He reported himself as being right-handed. He stated that he left Ruffington Middle School at the age of 16 or 17, he has been told he has a second or third grade education, and he is now in an adult reading program with a tutor who is working with him on Book III. He reported that other people fill out his job applications. The Claimant testified that before he became a member of the longshore union, he had a job sweeping out the union hall.

The Claimant testified that he was treated by Dr. Wardell for a back injury at one time prior to his current injury in July 2004. After that injury he returned to work at Virginia International Terminals ("VIT") as a truck driver and lasher, but was not in a regular gang. He testified that around midnight on July 6, 2004, he was working on a ship as a lasher when a crewman came by and knocked over a three-high lashing rod. The lashing rod hit him on the hard hat and right shoulder. He reported that he had problems with his head and neck for over a year prior to the July 2004 injury, but had not had any right shoulder problems prior to the July 2004 injury.

The Claimant testified that he did not understand the operations performed on him and that neither the operations nor physical therapy helped him. He reported returning to work for three days on the sling and forklift and then stopping work. He stated Dr. Wardell sent him to Dr. Mingione who treated him for pain, high-blood pressure, and depression. He reported that he is depressed because "[w]on't no one give me a job . . . [because] it went around that I couldn't do the job." He reported that he sometimes uses his arm sling but the therapist told him not to use it. He reported that he has received injections for pain since 2005 and the relief lasts from three days to a month, depending on the pain. He also reported Dr. Mingione prescribed oxycodone the week before the hearing and that he does not take it if he is leaving the house because it makes him sleepy.

The Claimant testified that he was sent for a chest x-ray and "the lady there wanted to take blood out of one arm and put it in the other arm, and then tried to get me to move my arm [over my head] and I couldn't move my arm . . . like she wanted because it was so much pain." He stated that he drives his car with his left and that driving a car is different that driving a hustler and

forklift because of the potholes and railroad tracks and the need to use both of his hands, arms, and shoulders all the time. He stated that when he attached and detached twist locks, he used both hands, sometimes raised both hands overhead to get the locks, and had to pull pins and twist the locks, which could be hard at times.

The Claimant testified that he can drink a soda and use a cell phone with his right arm but cannot get his hand over a 90-degree angle. He has full extension on the left shoulder. He stated he has never told of pain when it was not there and has never exaggerated the pain.

The Claimant testified that between January 19, 2006, and March 22, 2006 he signed up for longshore jobs because his prior representative recommended he do so, but he was not taken "because they knowed (sic) that I couldn't do the work."

On cross-examination the Claimant testified that he signed up for general longshoreman jobs, but no one would give him one. He reported that there was a file in the Hines Center regarding the work he could and could not perform and that, because of the file, it did not matter how much seniority he had, no one had to take him. He did not file a grievance over it, though, because he knew he could not do the work and he told the union that he could not do certain jobs.

The Claimant reported that he applied for all the jobs that came up at the Hines Center and he asked people for work. He testified that he was not willing to take a hustler driver job at that time because he could not do it, but he was willing to take a general longshoreman job handling twist locks. He reiterated that no one would take him because they knew he could not do the job. He stated that he would have gone and tried to do the job if someone would have taken him.

The Claimant testified that he has always been right-handed. He stated that he did not know why Dr. Wardell would have written that he is ambidextrous in his June 21, 2001, note, because he is not. He reported that he did not think he saw Dr. Wardell in 2001 for treatment of a right hand injury, but that he thought a female doctor in Dr. Wardell's office had treated him.

The Claimant testified that when he was last in school, he was in a special class and was on a second or third grade level. He did not remember how old he was or what grade he had been in before he was put in the special class. He then admitted to telling "a little white lie" in his deposition when he testified that he had gone through second or third grade because it was too embarrassing to let anyone know he had gone to Ruffington Middle School, which is a junior high school.

The Claimant recalled that he had seen Dr. Gerstle for testing on Dr. Mingione's referral. He stated that he has never told anyone that he graduated from high school. He also stated that if Dr. Gerstle said he graduated high school, it was because he did not understand something Dr. Gerstle said.

The Claimant admitted to having back problems before Dr. Wardell treated him in 2000. He admitted his deposition testimony was inaccurate when he testified that he did not have a head injury prior to July 7, 2004, because he did have a head injury prior to that date. He reported that he bumped his head in an auto accident, but it was so long ago that he was not sure if he had a

concussion. He stated that his deposition testimony that he had never had any injuries or problems with his right shoulder and arm before July 7, 2004, was correct.

The Claimant testified that he worked primarily as a truck driver during the year before his 2004 injury, but he also worked as a lasher. He stated that he was driving trucks a lot and that in a normal week, he would drive a couple of days and lash maybe two or three days. He stated that how many days he did each job depended on what was available, since he was catching jobs. He reported that he liked lashing work because it paid more, the jobs lasted longer, and since many people do not like to lash because of the hard work, he did not have any problems getting a job once people knew he could lash. The Claimant also testified that he would take general longshoreman jobs handling twist locks whenever he could get them.

The Claimant reported that the injection in his shoulder would sometimes last a month, but sometimes would not work at all. He stated that the pain was always there, even when the injection worked. He testified that he got an injection about once a month and it would remove the pain for a couple of days or a week, but he was still not totally pain free during that time. He stated that it was hard to say how much pain he would still have because he never knew when it was going to happen. He did state that it was still shooting, stabbing pain, but he just would not "have to take that pain as often."

The Claimant testified that Dr. Mingione had taken him off oxycodone for at least two or three months prior to November 7, 2006. He could not remember the last time he took oxycodone before that date. He also could not remember exactly when Dr. Mingione stopped prescribing oxycodone.

Not all containers use twist locks, the Claimant testified. He reported that if the containers were in the hold of the ship, they did not need twist locks, but there were pins in them. He stated that if the container did not have a twist lock, he still had to go and unlock the pin on the truck so the crane could take the container off the truck and put it on the ship. He explained that even if a straddle carrier was used to put the container on the truck, he still had to make sure it was not locked because the truck could have hit a bump and a pin could have locked. He stated that he had to make sure the container was not locked to the truck because if it was, the whole truck would be picked up with the container. He also stated that there are no twist locks in the corners when straddle carriers are used, but if the container is sitting on the pavement, he has to put pins in and turn them for when the container is put down.

The Claimant reported that he does not go to church as often now because he is in so much pain at times. He stated that he stopped going as much after his injury, but he did not know how long after, because the pain made it hard to remember. He did not remember whether the testimony at his November 10, 2005, deposition that he went to church practically every day was accurate.

The Claimant next testified that he was receiving $371 a week in disability benefits after taxes and $1,680 per month in Social Security benefits. He reported that, after his injury, disability insurance was paying a car note of $820 per month and a personal loan, but he did not know the amount of that loan He did not think it was more than $200 a month. He testified that he also

filed a third party suit against the ship where he was hurt, but he did not know if the case was still pending.

The Claimant reported that he returned to work for a few days in February of 2005. He stated that he did not work long, but he stayed on the job. He claimed that he was paid four hours of straight time, 8.5 hours of overtime, and one hour of double time on the first day because "[s]omebody cared something about me to help me out." He gave the same reason for why he was paid on the second and third days, even though he did not do any work.

Next, counsel for the Employer played excerpts from a surveillance video of August 8-9, 2005. The Claimant testified that he was the man in the video. The first five excerpts were from August 8. At 11:54 a.m., the tape showed the Claimant in his car. At 12:33 p.m., the Claimant was shown in a conversion van, which he testified he owned. He stated that he was using only his right arm to steer the van while backing up because he was holding a cell phone in his left hand, but he only used his right arm to rotate. At 12:35 p.m., the tape showed the Claimant bringing his right hand up to his head and adjusting his glasses, which the Claimant acknowledged does not cause him problems. At 12:36 p.m., the Claimant scratched his ear with his right arm and he acknowledged on the stand that he did so. Four minutes later, the Claimant was again shown steering, but he testified that he was using his left arm. The next day, August 9, the Claimant was shown walking down steps and reaching up to close the trunk of his BMW.

The Claimant testified that he did not think he told Dr. Cohn he could only move his arm twenty degrees from his body, even though he may have been in a lot of pain at that time. Counsel for the Employer then played excerpts from a second surveillance video from January 31 and February 3, 2006. The Claimant confirmed he was the man in the video. At 4:54 p.m. on January 31, the Claimant was seen putting on a jacket with his arm in a sling. He stated that he sometimes does not have much of a problem putting on his jacket. The remaining excerpts were from February 3. At 11:33 a.m., the Claimant was seen on a balcony and his arm was not in a sling. At 11:35 a.m., the Claimant was seen gesturing with his right arm. He was still gesturing with his right arm at 11:38 a.m. and 11:42 a.m. He remained on the balcony until 11:45 a.m. Twelve minutes later, the Claimant was outside his apartment with his arm in a sling. At 12:01 p.m., he was seen talking with someone, but he could not recall what they were talking about, other than parking spots. He also reached up to turn his hat backward with the hand in the sling at that time, which he testified does not cause him problems. Finally, at 12:40 p.m., the Claimant was seen holding a cell phone up to his right ear with his arm still in the sling.

The Claimant testified he did not know how he got a note from Dr. Wardell's office, dated December 16, 2005, which stated that he could not use his right arm at work at all, but he could use his right arm for "activities of daily living." He stated that he did not remember going to Dr. Wardell for the note or why.

On redirect examination, the Claimant testified that he did not know whether a suit had been filed for his third-party case. He also stated that he is not paying his car note and insurance is not paying it, either. He further testified that the other workers would not cover for him on a regular basis like they did in February of 2005 when he only worked a few days.

On re-cross examination, the Claimant stated that the other men covered for him in February of 2005 because he had begged for the job as he really needed it. He stated that he really needs money now, as well.

The Claimant's counsel later called the Claimant in rebuttal to the Employer's case. On direct examination, the Claimant testified that the hatch boss shapes the gang, but he could send a different man to shape the gang if he wanted. He stated that he calls twist locks pins. He testified that most of the time when he is working with twist locks, the container is above his shoulders. He stated you can ask the operator to lower the container, but sometimes they will not bring the container down and will threaten to call another longshoreman to do the work.

On cross-examination, the Claimant testified that when a container is taken off a ship, it is put on the ground so it can be picked up by a straddle carrier. He stated that sometimes the operators put the container on a chassis instead of on the ground, but he has not been to the port in a while, so he did not have any reason to dispute Mr. Parker's testimony that they use straddle carriers now instead of chassis. He then stated that the operators do not put the container on the ground all the time because the straddle carriers do not always pick up the containers. He repeated that the containers are sometimes still put on chassis. He stated that if there was no use for the chassis as Mr. Parker testified, there was no use for the trucks, but the trucks are still out there to pick up the chassis.

The Claimant testified that he went to his union representative after he had checked-in for two months and did not get a job. He stated that the union representative told him that he did not get a job because he was not able to do the jobs. He reported that the union representative knew he could not do the job because someone told him. He testified that he still signed up for jobs he said he could not do because he was told to do so by his attorney.

Testimony of W. Parker (TR 87 to 120)

Mr. Parker testified that he is vice-president of Ceres Marine Terminals and is in charge of the Hampton Roads operations. He stated that the terminals covered were NIT, PMT, Newport News Navy Base, and Lambert's Point dock. He stated that the Claimant had worked at some of those places.

Counsel for the Employer showed the witness EX 7, which he identified as a work history from the Hines Building with the Hampton Roads Shipping Association. He reported that "ST" stands for straight-time hours, "OT" stands for overtime hours, and "DT" stands for double-time hours. He stated that overtime is 1.5 times straight-time and double-time is double straight-time. He testified that overtime hours are not mandatory. Mr. Parker further testified that "L" stands for general longshoreman or driver, "D" stands for driver, and "L3" stands for lasher.

Counsel next showed Mr. Parker EX 64, which he identified as a work history he made. He testified that he pulled four weeks of Ceres gang history, took out the work done by regular gang members, and just looked at the work done by members who were catching jobs at the hall. He stated that all the jobs listed in the first two weeks were general longshoreman jobs where the person would be handling twist locks and the jobs listed for the last two weeks were all driving

jobs in a dock gang. He testified that all the jobs were ones the Claimant could have worked because people with less seniority than the Claimant actually worked them and if the Claimant had been there, his seniority would have bumped them. Mr. Parker explained that a longshoreman who is not in a gang or whose gang is not up will go down to the union hall to catch a job. The longshoreman puts his name in and is assigned by job category and seniority when jobs come up. He stated that the people with the lowest letter get chosen first, because those with the most seniority have the lowest letters.[5]

Mr. Parker testified that, to get the monetary figures in EX 64, he looked up the ships and time sheets for the gang that had the person with the lowest seniority, found out how many hours the gang worked, and then determined what the Claimant would have made. For example, on December 19, the gang for Morris Crystal worked five overtime and eight double-time hours at a rate of $27 per straight-time hour.

Upon questioning by this Administrative Law Judge, Mr. Parker stated that the entries for the Driscol and the Stockard Express were for two different shifts. The hours listed were for the gang and if the Claimant had taken a job, he would have made that number of hours. He testified that there are thirteen people in a gang, excluding the crane operators and each member of the gang makes the same number of hours. He stated that the regular members of each gang could be of different seniority levels (A through M), but they would work the job regardless because they were assigned to that gang and could not be bumped. He stated that aside from the regular members, there were usually one or two openings and the hatch boss would go to the hall to shape the gang. The hall would then send people by their category. Mr. Parker stated that, had the Claimant shaped, he would have been sent before the others that were sent and could have worked each of the ships on the list for the number of hours listed because he had a G card and those that did work were H to M cards.

Upon examination by counsel for the Employer, Mr. Parker testified that the Claimant would have been entitled to container royalties and vacation and holiday pay if he had worked enough hours. He stated that if the Claimant had worked at the rate represented in EX 64, he would have enough hours to qualify. He was not sure if container royalties and vacation and holiday pay were more or less than in 2003, but he knew container royalties were about $8,100 recently. He further stated that vacation and holiday pay would probably have gone up with the new contracts and pay scales, but he was not sure.

Mr. Parker testified that the jobs listed in EX 64 were only jobs with Ceres. At the time he made the list, Ceres was doing about 30-35% of the container vessels that came into port. He stated that the other employers would also have had openings in their gangs.

Counsel for the Employer showed Mr. Parker EX 69 and he identified page two as a description for a general longshoreman for container vessels. He reported that that person handled twist locks and that he had changed the weight of the twist locks on the job description from thirteen to eighteen pounds. He stated that he originally made the job description using descriptions from other ports and he checked the job duties and physical activity required, but assumed the weights were accurate. He was notified that there was a question regarding the weights, so he brought in

[5] Thus, an A card has more seniority than a C card.

his bathroom scale and weighed a half-dozen twist locks. He weighed the lightest one at 14.2 pounds and the heaviest one at 16.8 pounds, so he changed the weight on the job description to seventeen pounds. He was then notified that the Claimant's counsel found a twist lock that was heavier than seventeen pounds, so he changed the weight to eighteen pounds. He testified that a person uses both hands to put twist locks in place, but it is possible to put most of the weight in one hand and use the other hand for positioning.

Mr. Parker testified that page 3 of EX 69 was a job description for a slinger/spotter on a container ship. He stated that it is similar to the job of general longshoreman, except the person carries a radio to communicate with the ship's crane operator and gang wingman. He changed the weight of the twist locks on that job description as well, for the same reasons as above.

Mr. Parker identified EX 71 as the job description for a light duty painter/power washer. He stated that it was a job Ceres was ready to give the Claimant. He reported that it paid $20 per hour, forty hours per week. All the Claimant would have to do is call Mr. Parker and he would be put to work the next day. Mr. Parker testified that the weight restriction in the job description was changed from fifty-six pounds on a previous description to twenty pounds in EX 71. He stated that he got the original job description the same way he got the description for the general longshoreman job and assumed the weight restrictions were correct until he talked to his shop manager, who supervised the light duty painters and power washers. The shop manager told Mr. Parker that the only thing a person had to carry for the job was cleaning fluid for the power washer which would not be more than twenty pounds, so Mr. Parker changed the description.

Mr. Parker testified that page 4 of EX 69 was a hustler driver job description. He reported that all the trucks for the job had power steering and automatic transmissions. He also reported that the seats were air-cushioned and could be adjusted to the driver's weight.

On cross-examination, Mr. Parker stated that he is a 1974 graduate of the Maine Maritime Academy and was on Coast Guard Reserve active duty from 1974 to 1977. Between 1977 and 1986, Mr. Parker worked for Mid Gulf Stevedores in New Orleans, Levino Shipping Company, Eller & Company, and Nacirema Operating Company. In 1986, Ceres bought Nacirema and Mr. Parker stayed with Ceres. In 1988, he became a manager of stevedoring with Ceres; in 1999, he became general manager of Ceres; and in May of 2005, he became vice-president of Ceres.

Mr. Parker testified that the twist locks used in each port are the same and that he is very familiar with them. He stated that he has picked them up, but has never put them in or taken them out of containers. He reported that the twist locks used now are semi-automatic and were used beginning around 1988, but that prior to 1988, twist locks were manual and were much lighter than the semi-automatic locks. He stated that he did not know their actual weights until recently.

The witness stated that he did not know whether he signed off on a job description that showed that twist locks weighed eight pounds. On questioning by this Administrative Law Judge, Mr. Parker testified that he could have signed off on job analyses that indicated that twist locks weighed less than eighteen pounds. Upon being shown CX 19 by the Claimant's counsel, Mr. Parker identified his signature on a job description from August of 1999 that showed that twist locks weighed eight pounds. He stated that this regular duty job analysis was used until the

recent correction. Prior to 1999, he stated, he never really thought about whether the twist locks used were heavier than eight pounds.

With respect to CX 64, Mr. Parker testified that, had the Claimant shaped for every ship listed, he would have worked that number of hours and earned the amount of money listed. He stated that none of the gangs on the list were full at that time and they all needed extra people. He knew this based on the check-in form used for each of the house gangs, which lists by port numbers all the regular members of the gang, who are assigned first. Below that list, there is a list of port numbers for people who shaped for each ship and the add-on people are checked off as they come in.

Mr. Parker testified that the hatch boss makes the decision as to whether he needs extra workers. The hatch boss goes to the union hall to request a general longshoreman and the hall dispatches a person by seniority. The hatch boss cannot choose a lower seniority person over one with higher seniority. Mr. Parker did admit that he has known hatch bosses to be "undemocratic" as to the person they choose as the extra. He stated that most of the regular members of a gang would stay to complete the work on a vessel, even if they had to work overtime, so the hall would not have to dispatch an extra person to work the overtime.

Mr. Parker did not know that the Claimant had signed up for work from January 19, 2006, through March 22, 2006, but that period was not covered by EX 64. He could not explain why the Claimant never got a job during that period of time. He stated that it could have been because the other longshoremen knew the Claimant could not carry his own weight.

On redirect examination, Mr. Parker stated that the hall would not have dispatched the Claimant if he told the dispatcher that he could not do the work. If the Claimant had insisted on being dispatched anyway based on his seniority, the Claimant could have the union representative bring the dispatcher up on charges. Mr. Parker also stated that when he said the hatch bosses were undemocratic, he meant that they "go around the system," but they can be brought in front of the district counsel and fined if they do so.

On examination by this Administrative Law Judge, Mr. Parker testified that gang members are not supposed to carry work for another gang member if he is hurt or sick, but it happens. He opined that, based on his observations, a person could not perform the light duty painter/power washer job if he could not raise his dominant hand above shoulder level.

Mr. Parker repeated that, although he has not inserted or removed twist locks, he has watched. He stated that to put in a twist lock, the worker supports the lock with one hand, pulls out the handle, pulls it up, and twists it, which locks it into the container. To take out a lock, they do the reverse. He reported that it appeared that a fair amount of force is necessary to pull out the pin while holding the twist lock. He stated that the workers do not have to work at shoulder height because the crane operators will lower the containers down to where it is comfortable to work, which is usually about waist height. Mr. Parker testified that the number of containers varies depending on the vessels that come in, as some ships have a lot of deck work and a lot of twist locks and some ships have only a few containers on deck, with the rest of the work below deck where there are no twist locks, just pins. In an eight hour work day, Mr. Parker estimated that a

worker would spend about two to three hours per day working with twist locks, because the majority of the containers are below deck.

On recross examination, Mr. Parker testified that most of the crane operators are VIT employees, except for at Universal. He stated that production from the operators depends on the vessels they are working on and that there is no rule, written or unwritten, that if they could not do at least thirty containers per hour, they could not be crane operators. He reported that there are no more chassis that go on the cranes and the only containers that are still on wheels are over-high and hazardous containers, which is a very small percentage. The majority of work is now straddle carrier work and the operators average thirty-two to thirty-three moves per hour. He also reported that at NIT, the transdainer operators average twenty-five or twenty-six containers per hour. Mr. Parker stated that the containers are about eight or nine deep on a standard cargo ship. He further stated that the containers are usually five high above deck.

Mr. Parker testified that if crane operators put containers over the longshoreman's head, many times, the longshoreman will wait until the operator lowers the container to a comfortable spot before he will put the twist lock in or remove it. He stated that the operator will always lower the container if the longshoreman just stands there. He also stated that if it were him, he would wait until the container was lowered. He reported seeing longshoreman motion to the crane operator to lower the container and stated that the operator always brings the container down.

On further redirect examination, Mr. Parker testified that he has used a power washer. He stated that, to clean the equipment correctly, sometimes you have to use the washer above your head.

Medical and Psychological Evidence:

Dr. A. Wardell, M.D. – Medical Records & Reports (CX 16; EX 11, 12, 16, 18, 20, 21, and 56); Deposition (CX 1)

CX 16, EX 11, EX 12, EX 14, EX 18; EX 20; and EX 21 contain the medical records of Dr. Wardell. Dr. Wardell first saw the Claimant for his work-related injury on July 12, 2004. The Claimant complained of neck pain that radiated into his right shoulder and numbness in his right hand. He told Dr. Wardell he was a fifty-five-year-old, right-handed longshoreman who injured his neck and right shoulder when a rod hit him on the head, neck, and right shoulder. On examination, the Claimant had right paracervical and parathoracic tenderness, right trapezius tenderness and spasm, right deltoid tenderness, and right AC joint tenderness. His neck motion was restricted about 50% percent in extension, flexion, and rotation and he could only raise his shoulder about ten degrees. His grip strength was five pounds on the right and seventy pounds on the left. X-rays of the dorsal and cervical spine revealed no fracture or dislocation. Dr. Wardell diagnosed a cervical spine sprain, dorsal spine sprain, right shoulder sprain, and right AC joint sprain. He prescribed physical therapy, Vicodin, and a sling for the Claimant's right shoulder. He also instructed the Claimant to remain out of work and return in two weeks.

The Claimant returned on July 21, 2004, earlier than his next appointment, because of increased right side neck and shoulder pain, tingling in his right hand, and decreased sensation in his right index finger. He reported little relief from the two physical therapy sessions. On examination,

he had a 75% restriction of neck motion, right paracervical and trapezius tenderness and spasm. He had AC joint and anterior acromion tenderness. Active right shoulder flexion was eighty degrees and abduction was limited to seventy degrees. Dr. Wardell gave the Claimant an injection, a sling, and prescriptions for Flexeril and Mepergan Forte. He instructed the Claimant to continue physical therapy and remain out of work.

At the next visit on July 26, 2004, the Claimant stated that the injections had helped for a short period of time. On examination, the Claimant had a 50% restriction of neck flexion, a right trapezius trigger point, deltoid tenderness and anterior acromion tenderness. He received another injection and was scheduled for an MRI to rule out a rotator cuff tear. Two days later, the Claimant returned complaining of headaches, neck pain, and continued shoulder pain, although physical therapy was helping a little. On examination, he had a 75% restriction of neck motion, right paracervical and trapezius tenderness, and AC joint and anterior acromion tenderness. Dr. Wardell gave the Claimant prescriptions for Vicodin and Flexeril and instructed him to continue physical therapy and remain out of work.

Dr. Wardell sent a letter to the Employer on August 3, 2004. He opined that the Claimant's diagnosis was causally related to his injury and that the Claimant was not capable of any work at present.

The Claimant underwent an MRI on August 3, 2004.[6] The impression was "tendinosis with a focal full-thickness tear of the anterior fibers of the supraspinatus tendon," "tendinosis with thickening of the subscapularis tendon," "mild infraspinatus tendinosis," "slight posterior subluxation of the humeral head," "type II acromion in the sagittal plane," and "moderate acromioclavicular joint osteoarthritis." On August 12, 2004, Dr. Wardell reviewed the MRI and noted the right rotator cuff tear. The Claimant complained of pain radiating from his neck to his right shoulder. He had restricted neck motion and right paracervical and trapezius tenderness. His right shoulder elevation was sixty degrees. Dr. Wardell recommended right shoulder arthroscopy, acromioplasty, distal clavicle excision, and rotator cuff repair. He sent the Claimant for an EMG of the right upper extremity.

Dr. Wardell performed surgery on the Claimant on September 21, 2004.[7] The pre-operative diagnosis was a right shoulder rotator cuff tear. The procedure consisted of arthroscopy, arthroscopic bursectomy and acromioplasty, arthroscopic debridement of the biceps tendon, and open rotator cuff repair. The post-operative diagnosis was a right shoulder rotator cuff tear and a partial tear of the biceps tendon. At the first three post-operative visits, Dr. Wardell noted that the Claimant's pain was improving and at four weeks postop, he had full passive flexion with physical therapy. Dr. Wardell stated that he should resume physical therapy when he was able to start an active assisted range of motion and strengthening program. However, on November 11, 2004, the Claimant returned after slipping and falling down the stairs onto his right shoulder. He reported pain and examination revealed pain and tenderness to palpation over the anterior and middle deltoid. Active flexion and abduction were at sixty degrees, while passive flexion and abduction were at seventy degrees. Dr. Wardell diagnosed a right shoulder contusion and instructed the Claimant to remain out of work.

[6] EX 12 also contains a copy of this MRI report.
[7] EX 14 also contains a copy of the operative report.

The Claimant returned on November 26, 2004, complaining of neck and shoulder pain. Dr. Wardell noted right paracervical and trapezius tenderness and his right shoulder abduction was ninety degrees. His blood pressure was very elevated and Dr. Wardell instructed him to see a doctor for medication.

On December 1, 2004, the Claimant returned with discomfort and bilateral parathoracic and paralumbar tenderness. His right shoulder elevation was seventy degrees. Dr. Wardell released the Claimant to work, but placed full restrictions on his right shoulder and arm until reevaluation in four weeks. The Claimant was restricted to lifting less than ten pounds for less than two hours per day, he could not climb ladders, he could only perform gripping activities intermittently and less then twice per hour, he could not perform overhead work, and he could only perform desk work, typing, and cash register operation for less than one hour per day with intermittent breaks.

One month later, the Claimant returned complaining of right shoulder pain and decreased range of motion. On examination, his right shoulder had active flexion of 130 degrees, with pain beyond that angle, abduction of ninety degrees, internal rotation to L5, and passive flexion of 140 degrees with pain. Dr. Wardell instructed him to continue physical therapy and continue working with the previous restrictions.

On January 21, 2005, the Claimant's pain was no better, but no worse. He had right shoulder elevation of 130 degrees and anterior acromion tenderness. A few weeks later, he returned complaining of persistent right shoulder soreness. His right shoulder elevation was 120 degrees. Dr. Wardell released him to work with the restrictions given in his FCE.[8]

The Claimant had an ultrasound of his right shoulder on February 22, 2005. The report, dated March 7, 2005, showed bicipital tenosynovitis, early degenerative G-H joint, subdeltoid bursitis, AC joint synovitis, subacromial impingement, supraspinatus tendon defect, bursal surface defect, and probable full-thickness tear.[9] On February 24, 2005, the Claimant complained of worsening pain in his right shoulder, neck, and back and stated that operating a forklift at work had aggravated his pain. On examination, he had a 25% restriction of neck motion to the left, left paracervical and trapezius tenderness, supraspinatus tenderness, right shoulder flexion was 110 degrees, and right shoulder abduction was eighty degrees. Dr. Wardell instructed him to remain out of work until March 9, 2005, when he was reevaluated for increasing back and shoulder pain. On that date, he had restriction of low back flexion, bilateral lumbar tenderness, right deltoid tenderness, and right shoulder elevation was only ninety degrees. He was sent for a right shoulder MRI to rule out a rotator cuff tear and was instructed to remain out of work.

The MRI was performed on March 15, 2005, which showed no recurrent full-thickness tear, tendon retraction, or muscle atrophy, but there was some subacromial fluid.[10] Dr. Wardell reviewed the MRI results on March 25, 2005, and noted no signs of a recurrent rotator cuff tear. The Claimant was given an injection and Dr. Wardell mentioned performing a second surgery if there was no improvement. The Claimant was instructed to remain out of work until at least

[8] *See infra* EX 15.
[9] EX 18 also contains a copy of the ultrasound report.
[10] EX 20 also contains a copy of this MRI report.

April 8, 2005, when he returned for reevaluation. At that time, the Claimant reported no improvement in his right shoulder and that he had constant pain. He informed Dr. Wardell that he could not perform any motion without severe pain in his right arm. On examination, active flexion was eighty degrees and active abduction was seventy degrees, both with pain. Dr. Wardell instructed the Claimant to remain out of work, gave him a prescription for Vicodin, and scheduled a second surgery.

Dr. Wardell performed a second surgery on the Claimant's shoulder on May 5, 2005.[11] The pre-operative diagnosis was a retear of the right shoulder rotator cuff. Dr. Wardell performed arthroscopy, arthroscopic rotator cuff repair, and an open distal clavicle excision. The post-operative diagnosis was a retear of the right shoulder rotator cuff and acromioclavicular joint damage. The Claimant saw Dr. Wardell for post-operative follow-ups three times in May 2005. He was instructed to begin physical therapy at the first visit, but had not started yet by the second visit. At the second visit, he noted continued pain in his shoulder and he had tenderness to palpation. Dr. Wardell instructed him to begin physical therapy and remain out of work. At the third visit, the Claimant was still complaining of right shoulder and neck pain and had had two physical therapy sessions. He told Dr. Wardell the pain was so bad that he had gone to the emergency room the night before. On examination, he had tenderness and trigger points in the right trapezius and right paracervical. He refused injections for the trigger points and was instructed to continue with physical therapy.

The Claimant continued to complain of pain in his neck and right shoulder at his follow-up visits in July of 2005. A July 22, 2005, x-ray report showed no fractures, dislocations, or degenerative changes in his neck, back, or left shoulder. On week later, Dr. Wardell opined that the Claimant had likely reached maximum medical improvement and he recommended an FCE. He did so again on August 18, 2005, and on that date, there is also a notation that Dr. Wardell gave the Claimant an impairment rating, but there is no indication of what the rating was. Dr. Wardell continued to keep the Claimant out of work until September 29, 2005, when he released the Claimant to sedentary work.

On October 19, 2005, Dr. Wardell opined that the Claimant had reached maximum medical improvement and was capable of sedentary work only. He gave the Claimant a 30% permanent impairment rating of the right upper extremity due to the work-related injuries of July 7, 2004.

On December 2, 2005, Dr. Wardell opined that the Claimant "is totally disabled due to meds needed daily (oxycodone)." Two weeks later, on December 16, 2005, M. Ratanataya, PA-C, a certified physician's assistant in Dr. Wardell's office, noted that the Claimant was "advised to not use his right arm. However he has been encouraged by his physical therapist and treating physician to use his right arm for activities of daily living."[12] A few weeks later, on January 11, 2006, Dr. Wardell wrote a note stating that the Claimant "was seen in my office today. He is totally disabled." At that visit, Dr. Wardell noted deltoid tenderness and recommended another injection, since the December 27 injection had helped. From February 2006 to September 2006,

[11] EX 21 also contains a copy of this operative report.

[12] EX 56 contains a copy of the handwritten note from Mr. Ratanataya, which stated that the Claimant was "advised while at work to not use his right arm. However, he has been encouraged by his physical therapist and treating physician to use his right arm for activities of daily living, to prevent pain and maintain shoulder range of motion."

the Claimant returned every three to six weeks for injections. Dr. Wardell opined that "[a]lthough he has reached maximum medical improvement, he will require right subdeltoid injections for the most efficient management of his pain and to decrease his reliance on drugs."

CX 1 contains the transcript of Dr. Wardell's September 11, 2006, deposition. He testified that he received his M.D. degree from Cornell University Medical College in 1975 and was an intern and resident at the University of Michigan in the Department of General Surgery. He spent three years in the Department of Orthopedic Surgery at the University of Rochester, then came to the Tidewater area in 1980 to practice and has been here ever since. He became Board-certified in orthopedics on September 11, 1981. Dr. Wardell's curriculum vitae was marked as Claimant's Exhibit 1 for deposition purposes.[13]

Dr. Wardell testified that he treated the Claimant prior to July 7, 2004, for a back injury and that the Claimant returned to longshore work after treatment. The Claimant then saw him on July 12, 2004, for his July 7, 2004, injuries. Dr. Wardell testified regarding the history he took from the Claimant, the details of the Claimant's injury, and the results of his examination, which are contained in the physician's records discussed above. He stated that he saw the Claimant again on July 21, 2004, earlier than scheduled, and testified regarding the results of that examination, also contained in the physician's records discussed above.

Impingement tests and positive crossover tests, Dr. Wardell reported, are provocative tests whereby "the examiner performs a maneuver and asks the patient whether that elicits pain." An impingement test puts the rotator cuff under stress and if the test is positive, that result is consistent with rotator cuff damage. A crossover test puts the acromioclavicular joint under stress and if the test is positive, it indicates injury to that joint. Dr. Wardell testified that both tests on the Claimant were positive on July 26, 2004, so he scheduled an MRI.

Dr. Wardell stated that the Claimant returned on July 28, 2004, five days before his next scheduled appointment. He reported that the Claimant underwent an MRI on August 3, 2004, the report of which was marked as CXD 2 for deposition purposes. On that day, Dr. Wardell sent a letter to the Employer, stating that the Claimant's cervical spine, dorsal spine, and right shoulder sprains were causally related to his July 7, 2004, work injury

Dr. Wardell testified regarding the results of the MRI, which are discussed above. He reported that tendinosis is tearing of fibers in a tendon. He also reported that "subluxation of the humeral head" means that in the ball-and-socket joint of the shoulder, the ball is out of the socket. He stated that the supraspinatus tendon is a portion of the rotator cuff.

On a diagram provided by the Claimant's counsel, Dr. Wardell marked where the Claimant's full-thickness tear of the rotator cuff was located. Later, he marked the biceps tendon on that same diagram. While looking at a second diagram, which was of a torn portion of the supraspinatus, he stated that it appeared to be a "good representation of my surgical findings." These diagrams were marked as CXD 3 and 4, respectively. On another diagram, he circled the rotator cuff repair and stated that it was similar to the surgery performed on the Claimant, but he

[13] The following designation will be used for exhibits offered at Dr. Wardell's deposition – CXD.

also stated that the repair of the full-thickness biceps tear on that same diagram was not performed on the Claimant. This diagram was marked as CXD 5.

Dr. Wardell stated that he met with the Claimant on August 12, 2004, to review the MRI results. He testified that he recommended proceeding with the right shoulder arthroscopy and he scheduled the Claimant for surgery that day, which was to be performed on September 21, 2004. Dr. Wardell reported that he began with arthroscopic surgery to confirm the MRI findings and he noted the full-thickness rotator cuff tear and a 10% tear of the biceps tendon. During that portion of the surgery, he removed tissue, bone, and the torn part of the biceps tendon. He then repaired the rotator cuff with open surgery. He reported removing four millimeters of acromion and using a soft tissue anchor to repair the rotator cuff, which anchors the rotator cuff tendon to the bone using a special screw and suture material. The operative report was marked as CXD 7.

Up until late 2004, Dr. Wardell testified, he kept the Claimant out of work. At that time, he signed off on some waterfront jobs, but prohibited the Claimant from performing others. He reported that he ordered an ultrasound on February 22, 2005, and received the report on March 7, 2005, which was marked as CXD 6. The ultrasound showed inflammation in the acromioclavicular joint and the subdeltoid bursa and there was concern about the rotator cuff. Dr. Wardell stated that if he had had the report when he released the Claimant to work, he would not have approved any jobs because of inflammation and a potential retear of the rotator cuff.

Dr. Wardell next testified regarding his findings at the Claimant's February 24, 2005, and March 9, 2005, visits, which are discussed above. At the March 9 visit, he reported that he sent the Claimant for another MRI, which did not show recurrent tear. Dr. Wardell testified that he then decided to give the Claimant a steroid injection because he thought the Claimant was most likely suffering from inflammation. When the Claimant returned on April 8, 2005, noting no improvement, Dr. Wardell reported that he recommended a second surgery, which was performed on May 5, 2005. This operative report was marked as CXD 8. Dr. Wardell testified that the Claimant's rotator cuff had a partial thickness retear, which he repaired arthroscopically. He also removed part of the Claimant's distal clavicle in an open procedure. He used a diagram to show the portion of clavicle removed, which was marked as CXD 9.

Dr. Wardell testified regarding his findings during the Claimant's follow-up visits in May and July of 2005, which are discussed above. He reported that the Claimant was seeing Dr. Mingione, whom he had recommended, for pain management at the time. He also reported that the Claimant remained out of work and was in physical therapy. He testified that at the end of July, he believed the Claimant was nearing maximum medical improvement, so he recommended an FCE. Dr. Wardell testified that he gave the Claimant a permanent impairment rating of 30% in the right upper extremity. He later testified that the Claimant reached maximum medical improvement in the late summer of 2005.

Elevation and abduction are similar actions, but are not synonymous, Dr. Wardell stated. He explained that elevation is "raising the shoulder in . . . any plane that gives you the maximum elevation," while abduction is "raising the arm from the side of the body."

Dr. Wardell testified regarding his findings during the Claimant's visits from December 27, 2005, through September 1, 2006, which are discussed above. He reported that he gave the Claimant steroid injections at the majority of those visits because he thought that was the most effective way to manage the Claimant's pain and decrease his reliance on painkillers. After most of the Claimant's visits, Dr. Wardell talked with Ms. Harwell about the Claimant's treatment.

Dr. Wardell opined that the Claimant's complaints were consistent with clinical examinations and surgical findings. He also opined that, with a reasonable degree of medical certainty, the Claimant's right shoulder and cervical spine injuries were caused by his July 7, 2004, work injury.

Dr. Wardell read a letter he wrote on May 17, 2006, which was later marked as CXD 10. In that letter, Dr. Wardell stated that the Claimant "is unable to work due to limitation of motion in his right shoulder, right shoulder weakness, and neck and right shoulder pain. He takes strong narcotic pain medications on a regular basis, which further decreases his ability to function through a workday." He also read his note from January 11, 2006, which stated that the Claimant was totally disabled. It was marked as CXD 11. He opined, with a reasonable degree of medical certainty, that the Claimant's right shoulder and cervical spine injuries are the cause of his total disability. Dr. Wardell's bills from July 26, 2006, were marked as CDX 12.

On cross-examination, Dr. Wardell testified that the July 6, 2001, note referred to by counsel was written by Dr. Lannik, a hand surgeon he referred the Claimant to. He stated that, even though Dr. Lannik did not find an objective basis for the Claimant's subjective complaints regarding his right hand, he did.

Dr. Wardell stated that he usually sends people who have recovered from a herniated disk back to work, but will not usually allow them to do heavy-duty work because they are at a high risk for further injury. He reported that the Claimant had a herniated disk in 2000 and on August 7, 2000, he allowed the Claimant to return to full-time work based on Dr. Kerner's opinion.[14] However, upon review of his records, he noticed that he released the Claimant to full duty work about two months before Dr. Kerner's recommendation. He stated that he was not sure why he released the Claimant to full duty work at that time, but he thought it may have been based on a second review of the MRI findings, although there was no indication of a second review in his office notes. He stated that he would have to review the MRI again to know for sure.

Dr. Wardell reported that the Claimant's grip strength of fifty pounds on the right, measured on June 12, 2001, was well below normal. He stated that normal for the Claimant should have been at least ninety pounds, which was his grip strength on the left. He also stated that normal for a right-handed person would be "somewhat higher" on the right than left. When asked about the office note from that visit, which indicated that the Claimant was ambidextrous, he stated that he did not remember the Claimant telling him that in 2001, but any information in the office note would have come from the Claimant. He also stated that, on July 12, 2004, the nurse noted that the Claimant was right-handed, but testified that people do not usually change from being ambidextrous to being right-handed.

[14] Dr. Kerner was the Claimant's spine surgeon.

Dr. Wardell testified that he did not know there was a discrepancy between what the Claimant told him on July 12, 2004, regarding the work accident and his injuries, and what the Claimant told the emergency room. He did not know why he did not note the Claimant's prior back and neck problems in his office notes, although he was aware of those problems and had treated the Claimant for them previously.

Dr. Wardell stated that the normal recovery time for a sprain is six weeks to three months and that more than 90% of shoulder, ankle, and knee sprains recover in three months. He reported that people with spine sprains may have symptoms that linger longer than three months.

Dr. Wardell testified that the Claimant did not indicate that the September 21, 2004, surgery improved his shoulder. He reported that Major League baseball players and professional football players who have had rotator cuff surgery have returned to their respective sports after recovery, but he could not recall any longshoremen who returned to work after a rotator cuff injury. He did not know why it did not help the Claimant. He testified that he released the Claimant to work on December 1, 2004, with full right shoulder restrictions, but with no left arm restrictions. The Claimant was limited to lifting no more than ten pounds with his right arm, but Dr. Wardell stated that a typical adult male could probably lift thirty or forty pounds from floor to waist-level. Dr. Wardell stated that the restrictions no longer applied because of the Claimant's diminished function from use of narcotic drugs, specifically Oxycontin, which he believed Dr. Mingione prescribed. However, he stated that functionally, the Claimant could still do the things indicated on the above work release.

Dr. Wardell testified that he gave the Claimant injections to reduce his reliance on narcotic drugs, but stated he would have to ask Dr. Mingione if the Claimant's use had decreased. He recalled that the Claimant reported taking less after successful steroid injections, but did not say how much less. Dr. Wardell stated that he and Dr. Mingione had spoken about the Claimant, the last time being sometime before February of 2006. He stated that they discussed the Claimant's pain medication, his ability to drive, and the possibility of a closed-head injury. They also discussed whether the injections were working. Even though they had not spoken recently, Dr. Wardell testified that he has continued to give the Claimant injections.

Dr. Wardell stated that he had looked at the Claimant's first FCE report, which is how he determined the Claimant's functional capacities. He acknowledged that the Claimant was noted to have given submaximal effort. He did not know if he could agree with the notation that the Claimant had inconsistent results for the grip strength testing of his right hand because he did not know how the testers characterized inconsistent results. When asked about the Claimant's positive Waddell signs from the FCE, he explained that a Waddell sign is a sign of inconsistent behavior during testing of the back and that there are five different Waddell tests. He was not sure why the Claimant's FCE included Waddell tests, since the evaluation was for his shoulder. Dr. Wardell reported that he also reviewed the Claimant's second FCE report and he thought the Claimant's submaximal effort was not due to malingering, but was "probably fear of pain."

With regard to the jobs he approved in February of 2005, which are contained in EX 17, Dr. Wardell testified that he allowed the Claimant to attempt any work which was within the FCE restrictions. He reiterated that, had he known that the Claimant had a recurrent rotator cuff tear,

he would not have asked him to try any of those jobs. He stated that he did not know when the recurrent tear occurred, but he received the ultrasound noting the possibility in March.

Next, Dr. Wardell discussed the Claimant's May 5, 2005, surgery. He testified that the Claimant never told him this surgery improved his condition. He stated that the point of both surgeries was to make room for the Claimant's shoulder to move without pain and to attach healthy rotator cuff tissue to the bone so the rotator cuff could function normally. During the second surgery, he did not think he cut more acromion, but he repaired the partial recurrent rotator cuff tear and removed bone in the distal clavicle where the Claimant had cartilage damage. He did not have any objective tests that showed the surgery was not a success and he could not explain why it did not help. He later agreed with Dr. Cohn's assessment that, based on the objective results of the surgery, the Claimant could perform some longshore jobs.

Dr. Wardell stated that he knew Dr. Pellegrino, but was not sure he referred the Claimant to him, although Dr. Pellegrino's report showed he made the referral. He thought Dr. Mingione may have, but that he signed the authorization. He stated that the referral was made because Dr. Mingione was concerned that the Claimant had sustained a closed-head injury. He reported that Dr. Mingione also instructed the Claimant not to drive, which he thought was because the Claimant was taking narcotics. He acknowledged that there was no mention of narcotics in Dr. Mingione's letter to the Claimant instructing him not to drive and that it sounded like Dr. Mingione was not concerned about the Claimant's narcotic use.

When asked about the office note of December 16, 2005, advising the Claimant not to use his right arm at work, but to use it for activities of daily living, Dr. Wardell stated that he recalled seeing it in his file. He could not recall anyone asking him for the note or say why the note was given. He confirmed that it was written by his physician's assistant, but stated that he agreed with the "spirit" of the note. He stated that the reasoning behind it was that work activities "might be imposed on [the Claimant] where he forgets about the . . . shoulder and uses it inappropriately," causing a new injury. Thus, the Claimant was supposed to wear a sling while at work, although Dr. Wardell did not know of any time where the Claimant consciously overexerted himself at work. He testified that he has told other patients to wear a sling at work to remember not to use the arm, but told them they did not have to use it at home. He further stated that he encouraged the Claimant to use his shoulder while at home to strengthen it "when there is no imposition of activity which might endanger" it. Dr. Wardell stated that the note released the Claimant to try things outside of work at his own pace that he may not have been able to do at work where time limitations would be imposed. He testified that he had not given the Claimant these restrictions before and did not know why his assistant gave him the note months after he had reached maximum medical improvement.

Dr. Wardell testified again that he used the AMA Guides, Fifth Edition to calculate the Claimant's 30% impairment rating. He could not say what pages he relied on and he did not have the worksheet he used for the calculations because he did not usually keep it. He reported that he primarily used the Claimant's motion restrictions and weakness in abduction, flexion, and external rotation for the calculations. After getting the AMA Guide, Dr. Wardell stated that he used pages 476, 477, and 510. He stated that 5% of the Claimant's impairment was due to flexion loss, 4% was due to abduction motion loss, 12% was due to shoulder flexion weakness,

6% was due to shoulder abduction weakness, and 3% was due to shoulder external rotation weakness, which totals 30%. Dr. Wardell reported that he used flexion, abduction, and external rotation because those three planes of motion were the ones primarily involved with the Claimant's rotator cuff injury. He based the values on the amount of strength loss the Claimant appeared to have and gave the maximum percentages because he thought the Claimant had more than a 50% strength deficit. He stated that he used the results of his clinical examinations because he did not have test results to support his findings. Dr. Wardell did not think that he miscalculated the amount of impairment because he thought the guides awarded impairment ratings for loss of both shoulder motion and strength, but stated he would reconsider the rating if he had.

On re-direct examination, Dr. Wardell testified that the Claimant was cooperative when under his care. He reported that, when the Claimant went back to work to operate a forklift, he complained of increased neck and back pain, as well as increased shoulder pain. He stated that the Claimant attributed the increase in pain to operating the forklift.

Dr. Wardell reported that the EMG study performed while he was treating the Claimant's low back pain in 2000 and 2001 was normal and showed no radiculopathy. He stated that the last time he saw the Claimant for that injury was January 28, 2002, and the Claimant was set to return to full-duty work the following day. The next time he saw the Claimant was after his July 7, 2004, work injury.

Dr. Wardell stated that his May 17, 2006, letter was his final opinion on the Claimant's ability to work. He testified that the Claimant is not able to work because of right shoulder weakness, neck and right shoulder pain, and loss of motion in the right shoulder.

On recross examination, Dr. Wardell clarified that the Claimant had two EMGs in June of 2001, one of the upper extremities and one of the lower extremities, and both were normal, even thought the Claimant was still complaining of pain. He reported that the Claimant's lower extremity EMG from June 22, 2000, had also been normal. The EMG report was marked as CXD 13. He stated that the last time he examined the Claimant's back, June 12, 2001, he was still experiencing pain.

Dr. Wardell testified that the Claimant's rating was based on the objective finding of impairment of the rotator cuff and the subjective range of motion and loss of strength findings. He reported that he had not done any objective strength tests. He agreed that the Claimant gave suboptimal effort during his FCE, but he thought that was due to the Claimant's perception that the activity would hurt. He stated that there was no relationship between the Claimant's submaximal effort and the positive Waddell signs he exhibited. In Dr. Wardell's opinion, the Claimant's pain was real to the Claimant and he stated that pain management doctors do not view Waddell tests as valid for pain behavior, even though a positive Waddell test means that the person complained of pain when there was no anatomical basis. He opined that a patient with positive Waddell signs "is exhibiting a behavior which is more from fear of reinjury or hurting themselves than . . . faking." He acknowledged that he relied heavily on the Claimant's subjective complaints when making his opinions.

Dr. D. Mingione, M.D. – Medical Records (CX 9-1, 9-4 – 9-17, 9-19 – 30; EX 22, 29); Medical Report (CX 9-18; EX 54); Deposition (CX 2)

CX 9, EX 22, and EX 29 contain medical records from Dr. Mingione. The Claimant saw Dr. Mingione on May 9, 2005, on referral from Dr. Wardell. He complained of nightmares, continuing pain in his right shoulder, impaired memory and orientation, headaches, and impotency. Dr. Mingione opined that the Claimant had a high level of anxiety and that he needed an examination to assess his cognitive function.

The Claimant saw Dr. Mingione about once per month between June 13, 2005, and August 16, 2006, for pain management. He reported many of the same complaints at each visit, including high levels of pain in his right shoulder, headaches, anxiety, poor concentration and memory, decreased energy, uneasiness, depression, and sleep problems. At the first appointment, Dr. Mingione prescribed oxycodone, Gabitril, and Zestril, and stated that the Claimant needed a neurological evaluation and psychiatric testing. Dr. Mingione discontinued Gabitril at the second visit, but continued the oxycodone and prescribed Lunesta.

On August 9, 2005, Dr. Mingione instructed the Claimant not to drive. He sent the Claimant a letter on August 29, 2005, advising him again not to drive because of the difficulties with his memory. He cleared the Claimant to drive on October 31, 2005.

On August 24, 2005, Dr. Mingione gave the Claimant a starter pack of Namenda in addition to his prescriptions for oxycodone and Zestril. Dr. Mingione noted that the Claimant's wife reported a personality change in the Claimant after taking oxycodone. The Claimant was sent for a urine drug screen to ensure that he was not developing an addition to oxycodone and Dr. Mingione reduced his dosage. The next day, Dr. Mingione met with the Claimant's case manager, Ms. Harwell. They discussed Dr. Mingione's diagnosis of dementia and the "rapid pace of the cognitive impairment." He told her that he had instructed the Claimant not to drive and he mentioned the potential need for a guardian.

Dr. Mingione continued to prescribe oxycodone, Zestril, HCTZ, Namenda, and Lunesta at the next two visits. He interviewed the Claimant's wife on November 5, 2005, and she reported that the Claimant would have a few days of good mental functioning, but would relapse into impaired cognitive function. She stated that he tried to hide it, but she and others still noticed. She reported that he was not taking his Namenda because he thought it would give him Alzheimer's.

At his next visit, the Claimant reported that the oxycodone was not helping, so Dr. Mingione prescribed Ultram. He continued to take HCTZ and Zestril, but stopped taking Namenda. At the next two visits, Dr. Mingione prescribed Darvocet because the Ultram and oxycodone were sedating the Claimant. However, the next month, he prescribed oxycodone again, along with Lunesta, and instructed the Claimant to continue taking HCTZ and Zestril. There is no other mention of Darvocet in Dr. Mingione's records. At the Claimant's April 2006 visit, Dr. Mingione prescribed oxycodone and Zestril and instructed him to continue Lunesta and HCTZ. The next month, Dr. Mingione again prescribed oxycodone and Lexapro and continued the Claimant on Zestril and HCTZ. In June, July, and August of 2006, there is no mention of an oxycodone prescription and an outpatient medication record mentions May 2006 as the last time

the Claimant was prescribed oxycodone. At the last visit on August 16, 2006, Dr. Mingione noted that the Claimant thought he needed more surgery.

CX 9-18 and EX 54 contain copies of a report by Dr. Mingione dated December 22, 2005, following his review of the August 8-9, 2005, surveillance tape brought to him by Ms. Harwell. Dr. Mingione noted that the tape showed the Claimant performing various activities, including driving. He noted less "swing" to the Claimant's right arm in comparison to his left and that he more actively used his left arm, but he did use his right arm to open and close the car door and to reach over his head to close the car trunk. Dr. Mingione reported that "[h]is general demeanor through the filmed sequence does not demonstrate any abnormality in his behavior or facial appearance" and that the Claimant appeared to have full use of his right arm. He stated that the Claimant had never told him he had a loss of use to his arm, just that he had pain with particular movements. He also stated that he has seen the Claimant perform most of the same movements with his right arm and shoulder while observing him in the waiting room, in his office, and entering and exiting the office, except raising his right arm over his head. He reported that he never asked the Claimant to perform those activities, but relied on the reports by the Claimant's orthopedist and physical therapist. He stated that "[i]t is impossible to infer whether any of the movements seen on the video were performed with the experience of pain."

CX 2 contains a transcript from Dr. Mingione's September 26, 2006, deposition. He testified that he has been a licensed physician for almost fifty years, a psychiatrist for almost forty-five years, and doing pain work" for about twenty-six years. He has been in the community since 1962. He testified that he first saw the Claimant on May 9, 2005, for his July 7, 2004, injuries, and the last time he saw the Claimant was August 16, 2006.

Dr. Mingione stated that the Claimant's ability to present his history was limited by his intelligence, which the doctor classified as in the "mildly retarded range, with an IQ of about 67 to 72." He reported that he first saw the Claimant for his shoulder pain, but during the evaluation determined the Claimant needed an MRI and psychological and neurological consultations. For the neurological consultation, he referred the Claimant to Dr. Pellegrino. Dr. Mingione stated that the initial concern was that the Claimant was not responding to the pain medication, but during the first four or five visits, the Claimant's short-term memory became more confused, which made him think the Claimant may have had a closed-head injury. "Surprisingly," he stated, the confusion eventually cleared and the Claimant was left with a limited intellectual capacity and increasing depression. Dr. Mingione stated that the Claimant's use of prescription pain medication had been eliminated for several months prior and he just used non-narcotic over-the-counter pain medication.

Dr. Mingione reported that he met with Ms. Harwell, the Claimant's medical case manager, several times to discuss the Claimant's mental state, his non-responsiveness to medication, and the impact of the medication on his confusion and memory. He reported that he asked Ms. Harwell to get objective information about the Claimant's medical and work history. He stated that he never got any information from her and the only other source of information he had was the Claimant's wife, who told Dr. Mingione about the periods of confusion. He reported that the Claimant's wife also told him about changes to the Claimant's personality and memory since the injury. He also mentioned that he restricted the Claimant from driving at one point.

Dr. Mingione did not evaluate the Claimant's range of motion or strength, but made observations from seeing him in the office, in the waiting room, and on videotapes. He treated the Claimant mainly for right shoulder pain and stated that he could only make an assessment based on the Claimant's subjective reports. He stated that the Claimant told him the pain was becoming incapacitating, which Dr. Mingione opined was partially a function of the Claimant's depression and inability to be active. He described a cycle where the more pain the Claimant had, the less he could move his arm, but the less he moved his arm, the more pain he had. He opined that the Claimant's pain was both real to the Claimant and to Dr. Mingione as a pain management specialist. He stated that he did not think the Claimant was bright enough to malinger or exaggerate the pain without a doctor knowing. He opined that the Claimant's shoulder pain was consistent with the Claimant's work injury of July 7, 2004.

Dr. Mingione stated that he diagnosed the Claimant with increasing depression, but the antidepressants he prescribed were not helping much. He opined, with reasonable medical certainty, that, if the Claimant had not been injured on July 7, 2004, he would not have the pain, and if he did not have the pain, he would not be depressed. He reported that he was still treating the Claimant and would need to until a comfortable lifestyle could be established with respect to a job. He opined that the Claimant appeared to be giving up. He believed the Claimant was also not taking his anti-hypertensive medication. He reported that the last time he saw the Claimant his blood pressure was 185/120, which he stated was "essentially at stroke level." He stated that pain makes blood pressure rise, but the progression of the Claimant's hypertension indicated that he was likely borderline hypertensive before his injury.

Regarding his office note of October 31, 2005, Dr. Mingione testified that the Claimant complained of pain that would occur suddenly in the shoulder and move down the arm. The Claimant reported to him that it could be set off if he bumped into something and lasted anywhere from a few seconds to thirty minutes. Dr. Mingione reported that there was no improvement in pain, but his mood seemed brighter, so he released him to drive. He testified that the Claimant told him he wanted to work, but could not lift or pull.

On cross-examination, Dr. Mingione testified that he is not board-certified in psychiatry, but he is a diplomate in the American Academy of Pain Management and has been since 1983. He reported that he sees the Claimant about every four to six weeks.

Dr. Mingione testified that he has diagnosed malingering in patients before based on suspicion and specific psychological tests, but there is also a lack of knowledge of chronic pain processes versus good orthopedic healing. He testified that he would be surprised to see the Claimant raise his arm straight up in the air and wave it for ten or fifteen minutes, but it would not surprise him if the Claimant could do it just briefly.

Dr. Mingione reported that he had reviewed the Claimant's FCE reports and noted they showed submaximal effort. He stated that it means the examiner felt the Claimant was not putting forth full effort, but he did not know how to assess that and stated he would defer to the examiner's opinion. He also noted there were inconsistent results for grip strength and stated that the examiner felt the Claimant was not trying hard enough. Again he deferred to the examiner's

opinion because he did not know how to assess it. He testified that he was familiar with the AMA guideline, which states that if there is more than a twenty percent variance in grip strength, the person is not putting forth maximal effort.

Dr. Mingione was not as familiar with Waddell signs as an orthopedist, but he was familiar with the fact that there is no physiological reason a Waddell test should cause pain and that if a person complains of pain during the test, it is a positive Waddell sign. He reported that he has seen notation of Waddell signs in every orthopedist's report and thought every orthopedist did Waddell tests as part of their evaluation. He recalled seeing notation of three positive Waddell signs out of seven in the Claimant's FCE report.

With regard to the Claimant's confusion that "surprisingly" disappeared, Dr. Mingione testified that he was concerned the Claimant may have had a small stroke. He reported a small stroke could cause that, but the neurologist did not find evidence of a stroke. He could not explain why the Claimant had episodes of confusion before it went away completely. He did not know if the Claimant was just pretending to be confused until he told him not to drive.

Dr. Mingione testified that the only medication the Claimant was supposed to be on at that point was blood pressure medication because he had taken the Claimant off all other medications. He opined that antidepressants were not effective for the Claimant because his depression was based on the "reality" of being unable to be gainfully employed and antidepressants do not change that "reality." He also opined that there was no possibility that the Claimant was not depressed, he just thought that medication would not fix the Claimant's depression. He stated that working would be good for the Claimant to help him out of his depression. He did not know why the Claimant would not return to work at the light-duty jobs he was released to, but he had encouraged the Claimant to return to work and the Claimant told him he did not know what he could do. Dr. Mingione noted that the Claimant could sign his name but could not read. He stated that the psychologist noted the Claimant graduated from high school, but that was information the Claimant gave the psychologist, because he did not give it.

With respect to the Claimant's shoulder, Dr. Mingione testified that he would not give physical restrictions and would leave that entirely to the orthopedist. He reported that he had reviewed his own notes, Dr. Wardell's office notes, Dr. Pellegrino's report, Dr. Mansheim's report, emergency room records, laboratory reports, medication notes, MRIs and the accompanying reports, the letter he sent to Employer's counsel after reviewing surveillance video, and the psychologist's report. He could not explain why the Claimant told Dr. Cohn he could not move his elbow more than twenty degrees from his body, but a few days later he was using his arm a lot more, which Dr. Mingione saw on the surveillance video. The only explanation he could offer was that the Claimant's pain was inconsistent and the primary limitation of his arm movement was related to pain, so his ability to move his arm was inconsistent. He did not have any explanation as to why the Claimant's pain was inconsistent from psychiatric and pain management perspectives. He testified that he would allow the Claimant to use his arm in the same way at work as he would use it at home.

On re-direct examination, Dr. Mingione testified that he would defer to Dr. Wardell with regard to work restrictions. He noted that Dr. Wardell had found the Claimant totally disabled. He did

not think he made a mistake in his assessment of the Claimant or in his opinions, although the Claimant's was a challenging and puzzling case. On recross examination, Dr. Mingione testified that the Claimant was puzzling because of the persistence and extent of his depression. He stated that he was concerned about the Claimant's depression and blood pressure.

Dr. S. Cohn, M.D. – Curriculum Vitae (EX 45); Medical Reports (CX 10; EX 19, 28, 40, 41, 43, 60); November 29, 2005, Deposition (CX 5; EX 42); September 22, 2006, Deposition (CX 3; EX 57),

EX 45 is a copy of Dr. Cohn's curriculum vitae. Dr. Cohn received his M.D. from the University of Virginia. He is currently in private practice at Orthopaedic Associates of Virginia, and is on staff at four hospitals in Norfolk and Chesapeake, Virginia. He is licensed in Virginia, Michigan, and North Carolina and is certified by the National Board of Medical Examiners and the American Board of Orthopaedic Surgery.

CX 10, EX 19, EX 28, EX 40, EX 41, EX 43, and EX 60 contain copies of Dr. Cohn's medical reports. Dr. Cohn saw the Claimant on March 1, 2005, for his right shoulder injury. He noted that the Claimant stated his shoulder bothered him as much as it did before surgery. The Claimant denied pain radiating down to his hand or up his neck. Dr. Cohn noted that the Claimant reported he tried to return to work as a hustler driver, but had too much pain. On examination, the Claimant had full range of motion of the cervical spine. He could only elevate his right arm ninety degrees because of pain. With passive motion, Dr. Cohn could elevate it further, although the Claimant complained of pain. Dr. Cohn noted the Claimant's ability to use his right arm when it was close to his body. An x-ray revealed a type 2 acromion, a screw at the rotator cuff insertion of the greater tuberosity, and that the end of the anchor was proud relative to the bone. Dr. Cohn recommended a subacromial injection for diagnostic and therapeutic purposes and an MRI. He stated that it was difficult to determine whether the Claimant's pain was coming from his distal clavicle. He did not think the Claimant had reached maximum medical improvement if he wanted injections or another operation, but if he refused those, Dr. Cohn felt he had reached maximum medical improvement and needed permanent restrictions. Dr. Cohn also reviewed the Claimant's records, his FCE, and job descriptions and signed off on the jobs he felt were appropriate. He recommended the Claimant not perform any driving jobs or jobs where he would have to use his right arm overhead or lift a significant amount of weight.

Dr. Cohn saw the Claimant again on August 17, 2005. He noted that the Claimant had undergone a subacromial injection, arthroscopic evaluation, and open distal clavicle resection since his last examination. The Claimant described pain in his right trapezius area with radiation into his head. He would not move his right arm more than twenty degrees in any direction because of pain. The Claimant told Dr. Cohn that he did not want to undergo another surgery. On examination, Dr. Cohn noted no atrophy and reported a normal neurological examination. The x-ray revealed a well-flattened acromion and that the implant was still slightly proud, but Dr. Cohn stated that was not likely enough to cause symptoms. Dr. Cohn diagnosed the Claimant with "shoulder and neck pain status post shoulder surgery x2 with rotator cuff repair." He did not recommend more physical therapy, but did state that aquatherapy may give some relief. He opined that the Claimant's "primary problem is pain management" and that there appeared to be a "large psychological overlay to his problem." He recommended the Claimant

see pain management and psychological specialists to determine whether his symptoms were "organic in nature or due to a pain perception problem in addition to depression." Dr. Cohn stated that if the pain was not neurogenic, he did not know why it was so severe. He opined that the Claimant could not return to longshore work because of his complaints of pain and the psychological overlay, not because of the physical injury. He could not say whether those complaints and the psychological aspect were work-related. He further opined that the Claimant had reached maximum medical improvement and that further orthopedic treatment was not needed at that time.

Dr. Cohn's report of September 22, 2005, was based on an examination of the Claimant and Dr. Cohn's review of a surveillance video. On examination by Dr. Cohn, the Claimant was emotionally upset and crying, and he held his right arm in a protective manner. He would not actively use his right arm unless asked. Dr. Cohn then reviewed the surveillance tape. He noted that the Claimant seemed more comfortable using his right arm for everyday activities on the tape than in the office, but he also noted that the Claimant would hold his right arm protectively at times. He could not give an opinion as to the difference in use.

Dr. Cohn saw the Claimant again on November 30, 2005, after the Claimant had undergone a psychiatric examination. Dr. Cohn noted the psychiatrist's opinion that the Claimant was functionally illiterate and may be borderline mentally retarded. He also noted that the Claimant was being treated in a pain clinic and was taking Mobic, oxycodone, and Lunesta. The Claimant reported occasional sharp pain and a constant ache, which he described as numbness and tingling and which radiated up his neck and into the right side of his face. Dr. Cohn noted that the Claimant did not appear to be as protective of his right arm, but the Claimant told Dr. Cohn that he could not use his arm to drive and did not use it actively. On examination, the Claimant had no atrophy in his right shoulder and had well-healed scars, and there was no tenderness when Dr. Cohn palpated about the right shoulder, even though the Claimant reported tenderness. The Claimant could elevate his left arm to 150 degrees, but could only elevate his right arm about ninety degrees.[15] Dr. Cohn reported that the Claimant's "pain and/or apprehension" caused him to be unable to obtain reliable measurements of the Claimant's range of motion or strength in his right shoulder. Based on this evaluation, review of previous evaluations, and the Claimant's medical records, Dr. Cohn opined that the May 5, 2005, surgery was appropriate. Using the AMA Guidelines to the Evaluation of Permanent Impairment, Dr. Cohn gave the Claimant a 10% impairment rating because of his distal clavicle resection. He also gave the Claimant a 7% impairment rating for his right shoulder due to decreased range of motion, which was based on his experience with rotator cuff injury patients. Again using the AMA Guidelines, Dr. Cohn gave the Claimant a 16% impairment rating for the right upper extremity/shoulder.

Dr. Cohn signed off on job descriptions he deemed appropriate for the Claimant,[16] but did not make a determination as to any job which required driving. He stated that based on the Claimant's anatomical problem and his surgeries, he should be able to perform driving jobs, but his subjective complaints apparently prevent him from doing so. He requested that the Claimant have an FCE to determine whether he could drive a hustler. Dr. Cohn gave the Claimant work

[15] The report states that the Claimant could elevate his arm to 190 degrees, but Dr. Cohn testified in his deposition that it was ninety degrees.

[16] Dr. Cohn approved the following jobs: groundsman; winchman; slinger; and general longshoreman.

restrictions of driving less than thirty minutes per eight-hour shift until an FCE could be obtained, no climbing ladders, no crawling, no reaching above the right shoulder, and a pushing/pulling limit of five pounds with his right arm. He limited lifting/carrying from floor to waist to fifteen pounds, lifting/carrying from waist to overhead to ten pounds (left arm only), and pushing/pulling with the left arm to twenty pounds. Dr. Cohn did not restrict him from standing, sitting, walking, balancing, bending, stooping, kneeling, crouching, or squatting.

In December 5, 2005, letter, Dr. Cohn stated that there was a discrepancy between the Claimant's use of his right arm on the surveillance video and his use of his right arm when Dr. Cohn examined him on November 30. He could not explain the discrepancy, but stated the Claimant's use of his right arm to close the trunk of his car "was a one time use of his arm and we did not see him use it in an active repetitive fashion." Dr. Cohn opined that the Claimant could drive a hustler based on his anatomic problem, surgeries, objective findings, and the surveillance video, but still recommended an FCE to answer that question.

On January 31, 2006, the Claimant went to Dr. Cohn to get a note for his disability insurance company, but he did not bring any paperwork with him. He arrived at the office in a sling and told Dr. Cohn he could not elevate his arm more than ninety degrees.

Dr. Cohn's report of March 22, 2006, addresses the second surveillance video of the Claimant. He noted that the Claimant used his sling when out of the house, but still used his right arm in an active fashion. He found it convincing that the Claimant spoke on his cell phone for fifteen minutes while holding it in his left hand, but gestured actively with his right hand, moved his right hand away from his body, and reached up to scratch his head a couple of times. Dr. Cohn noted the Claimant's sharp motions with his right arm and stated that "in observing his condition at that time one would not be able to realize that his right arm was injured or painful in anyway." He also noted that the Claimant would answer his cell phone with his right arm while it was in a sling, even if he could have used his left arm, and he would actively use his right arm while driving vehicles without automatic transmission or power steering. Dr. Cohn opined to a degree of medical certainty that the Claimant should be cleared to drive a hustler based on objective evidence. He agreed that the Claimant's work restrictions should be based on objective findings rather than subjective complaints because of his inconsistent behavior and recommended restrictions for over shoulder-height use of his right arm based only on objective findings and surgical results.

CX 5 and EX 42 contain copies of the transcript of Dr. Cohn's November 29, 2005, deposition. Dr. Cohn testified that he is a Board-certified orthopedist with a subspecialty in sports medicine. He reported that he deals mainly with knee and shoulder injuries. He stated that he first saw the Claimant on March 1, 2005, for an independent medical evaluation of the Claimant's right shoulder. He reported that Ms. Harwell, the Claimant's medical case manager, asked him to address the Claimant's diagnosis, work restrictions, treatment plan, work status, and whether he was at maximum medical improvement. He did not know if Ms. Harwell was in the office at the time of the examination, but she was not in the exam room. He stated that he usually talked to her if she was present, but he did not specifically remember meeting with her about the Claimant.

Dr. Cohn testified that a rotator cuff tear causes shoulder pain and he normally recommended surgical repair, because the pain tends to worsen over time. He stated that, based on the MRI, he would have recommended surgery in the Claimant's situation and that the Claimant underwent the appropriate procedure. He then explained that the acromion is the bone over the rotator cuff and bursa around the shoulder, which is graded based on whether there are bone spurs or whether anything is impinging on the rotator cuff that would make it more susceptible to injury. A Type 2 acromion, which was seen on the Claimant's x-ray, does not have a large bone spur, but does have a small curve. He stated that the screw seen on the Claimant's x-ray was part of the rotator cuff repair. The screw, he explained, is placed into the ball of the shoulder and the suture attached to the screw is used to pull the rotator cuff tissue to the bone.

At the first examination, Dr. Cohn testified, he reviewed and approved some job descriptions, but disapproved any driving jobs because the Claimant's shoulder was bothering him too much. He reported that he had indicated the Claimant should not operate a forklift because of the repetitive arm use and use of the hand away from the body. He thought the Claimant's symptoms at the time caused it to be unsafe for him to operate such machinery in a dangerous work environment and he was concerned about the Claimant losing control and hurting someone. He stated that everyone's results are different, but he normally released people to drive. He further stated that it was not typical for him to give a restriction of no overhead work to someone with a small tear like the Claimant's and he had hoped the Claimant could do some overhead work about six months after the repair. The Claimant's result, he reported, was not "optimal" or what he hoped from a rotator cuff repair, but it was based more on the Claimant's complaints rather than his anatomic problem.

Dr. Cohn reviewed the lasher job description and testified that he would release a patient to do the job after surgery if the patient came to him with this description and said his shoulder felt good and he thought he could do the job. He did not know if he had ever released someone to do the lasher job after rotator cuff repair, nor did he know if he had ever refused to release someone to the lasher job who had rotator cuff repair. He testified that it is not typical, yet not uncommon, for him to give a restriction of no overhead lifting to someone who had two rotator cuff surgeries.

Dr. Cohn testified that on March 1, 2005, he felt the Claimant was at maximum medical improvement unless he had more surgery. His recommended course of action was to first give the Claimant an injection of numbing medicine in the subacromial space. If it lessened the pain, he stated, it would pinpoint the problem and indicate that the Claimant may need more surgery to investigate and fix his rotator cuff. He stated that the Claimant also had some arthritis in the joint where the collarbone meets the shoulder, but without the injection, it was hard to tell exactly where it was coming from because the Claimant's symptoms were vague.

On August 1, 2005, Dr. Cohn testified, he received another letter from Ms. Harwell requesting an examination and record review to determine a diagnosis, treatment plan, maximum medical improvement, whether the Claimant could return to longshore work, and recommended restrictions. He reexamined the Claimant on August 17, 2005, but did not remember if he had spoken to Ms. Harwell at that visit. He reported that the Claimant's May 5, 2005, surgery was reasonable, although it was hard to tell from the records if the injection test Dr. Wardell had

performed was positive or negative. If Dr. Wardell was convinced the pain was coming from the Claimant's shoulder, he stated, the surgery was reasonable even if the injection test was negative.

Dr. Cohn testified that, on review of the x-rays after surgery, the Claimant had a well-flattened acromion, which meant Dr. Wardell likely took off more bone during the second surgery. He reported that the screw was still a hair proud, meaning the top was almost flush with the bone rather than embedded in the bone. He stated that this was something that could cause pain, but he did not think it was sticking out enough to cause pain for the Claimant. Dr. Cohn testified that the Claimant also had a distal clavicle resection, which is where the end of the collarbone is removed to help with arthritis. He stated that the procedure was not significant and would not add much to the length of rehabilitation.

Dr. Cohn confirmed that at the August 17, 2005, evaluation, he thought the Claimant could not return to longshore work because of pain complaints, not an anatomical problem. He stated that he could not examine the Claimant well enough to know how his shoulder was functioning, but he did not think the Claimant could return to lashing because of pain complaints and because he appeared depressed. However, he could not say it was because of a physical problem.

Dr. Cohn testified that he had reviewed a video of the Claimant and testified regarding the contents of the letter he wrote to the Employer's counsel on September 22, 2005. He stated that the video did not change his opinion that he did not know what the Claimant could and could not do. He also stated that he did not know whether the Claimant could return to his lashing job at this time and he did not know if he would let the Claimant drive a forklift, either.

Dr. Cohn reported that he would be examining the Claimant again the day after the deposition. He stated that he was asked to give an opinion as to whether the May 5, 2005, surgery was appropriate, to comment on work restrictions and the jobs the Claimant could perform, and to give a rating for the Claimant's right shoulder based on the AMA guidelines. He reported that he did not need to meet with the Claimant to determine whether the surgery was appropriate and repeated that it was appropriate if the injection showed relief or if Dr. Wardell determined it was needed based on the Claimant's complaints. He stated that he needed to either meet with the Claimant or have copies of his physical therapy reports with shoulder motion and strength measurements to give a rating, although meeting with him would make it more accurate. The last time he examined the Claimant, he stated, it was not clear whether his shoulder hurt, he had pain from nerve impingement, or if his psychological issues were causing a problem. He testified that he would be able to answer the questions about work restrictions and jobs if he could get a more reliable examination and the Claimant told him his shoulder felt better. He stated that an FCE with reliable measurements could also help with ratings and work restrictions.

On cross-examination, Dr. Cohn testified that he gave the Claimant work restrictions based on his subjective complaints. He stated that the surveillance video suggested that the Claimant had times where he could use his arm more actively, though. He testified that the Claimant's action on the video of reaching up to close his car trunk was significantly different than what the Claimant told him he could do. Based on the video, Dr. Cohn stated that the Claimant's arm must have felt better than when he saw him. Dr. Cohn agreed that if the Claimant presented himself at a later FCE in the same way he presented to him at the office, it would suggest that the

Claimant was not accurately representing his abilities to medical providers. He stated that he was not sure the Claimant was doing it intentionally, but if the psychiatrist reported that the Claimant knew what he was doing at all times and was not depressed, it would lead him to believe that the Claimant is not representing his abilities correctly when he states he cannot use his arm. Dr. Cohn further stated that, had he just watched the surveillance film and reviewed the first FCE, he would have approved the Claimant to be a driver, but he did not release him because of his subjective complaints of pain.

Dr. Cohn stated that he hoped the second surgery would have improved the Claimant's condition, decreased his symptoms, and improved his functioning. He testified that there are Major League Baseball pitchers that have returned to pitching after rotator cuff surgery and he confirmed that pitching puts as much use on the rotator cuff as any other activity. He also testified that he would not know without looking at records whether he had ever released or not released anyone to work as a lasher after rotator cuff surgery.

Dr. Cohn reported that a direct blow to the shoulder can cause a rotator cuff tear. He did not know if a tear would occur if the lashing line hit the Claimant's head before hitting his shoulder. He reported that he has not seen many people hit by lashing rods, but it was hard to imagine a lashing rod first hitting someone on the head, then the shoulder, then the chest, causing a chest contusion.

Waddell nonorganic signs, Dr. Cohn reported, are tests used to determine whether someone is being honest and accurately portraying their symptoms. He stated that "[t]he more positive signs you have, the greater the indication that the person's not being accurate in their description of their symptoms." He confirmed that the testing consists of touching the person or asking them to do something that should not cause pain anatomically.

CX 3 and EX 57 contain copies of the transcript of Dr. Cohn's September 22, 2006, deposition. Dr. Cohn testified that he is an orthopedic surgeon and received his undergraduate and medical degrees from the University of Virginia. He is Board-certified by the American Board of Orthopedic Surgery and his practice consists mostly of patients with sports injuries, knee problems, and shoulder problems. He estimated that he performs 300-350 surgeries a year, where approximately half are shoulder operations, the majority of which are rotator cuff injuries. He explained that rotator cuffs are tendons that help move the shoulder.

Dr. Cohn reported that he saw the Claimant for independent medical examinations on March 1, 2005, August 17, 2005, September 22, 2005, and November 30, 2005, and the Claimant also walked in on January 31, 2006, for copies of records and notes. He stated that he reviewed Dr. Wardell's records, operative reports, and FCEs when asked to examine the Claimant.

Dr. Cohn testified that the Claimant had a rotator cuff injury. His understanding of the injury was that the Claimant was hit on the right shoulder with a rod while working as a lasher. The Claimant had already had shoulder surgery by the time Dr. Cohn saw him. Dr. Cohn reported that, according to the September 21, 2004, operative report the Claimant was diagnosed with a rotator cuff tear and partial tear of the biceps tendon. He explained that a rotator cuff tear is where the tendons that attach to the ball of the shoulder to help raise the shoulder are no longer

attached. He stated that a full thickness tear, which the Claimant had, means that the tendon was actually detached from the bone. He explained that a partial biceps tendon tear means that the biceps tendon inside the shoulder has some fraying, but is not completely torn.

Dr. Cohn then described the surgery performed by Dr. Wardell to repair the torn rotator cuff. He reported that Dr. Wardell placed an anchor in the bone of the ball part of the shoulder and sewed the tendon down to the bone with a suture attached to the anchor. He stated that the screw and suture hold the tendon against the bone until it "heals down," meaning scar tissue grows into the bone. Dr. Cohn testified that the procedure Dr. Wardell performed is typical and that he performs a couple per week. He reported that athletes who sustain rotator cuff tears generally can return to their sport, but it depends on the situation.

After surgery, Dr. Cohn testified, the Claimant underwent physical therapy and then had an FCE on January 18, 2005, to determine the Claimant's physical work tolerances, physical abilities and limitations, strength levels, and whether his complaints "made sense" given his injury. Dr. Cohn reported that, during an FCE, the examiners run many different tests and gradually increase resistance or difficulty until the person cannot complete the activity or complains of pain to determine a person's tolerance. He stated that the examiner looks for signs that the person is not giving maximal effort, such as low pulse rate while allegedly giving full effort or complaining of pain, ability to move injured extremities more while distracted, or inconsistent grip strength results. He stated that Waddell Nonorganic Signs are tests where the person is asked to do an activity that should not cause pain to the injury complained of to determine whether the person is giving a reliable answer. He reported that the notation on the Claimant's FCE that the Jamar grip testing scores were inconsistent meant that the examiner did not see the expected variation in grip strength that is usually seen when a person grips things of different sizes. Dr. Cohn testified that the FCE showed the Claimant was capable of performing light/medium duty work and the report described the Claimant's demonstrated abilities, which are indirect restrictions.

Dr. Cohn testified that he first saw the Claimant on March 1, 2005. He stated that the Claimant had attempted to return to work as a hustler driver, but stopped because of pain. He testified that the Claimant told him his shoulder bothered him as much as before surgery. He then testified regarding his findings on physical examination of the Claimant, which are discussed above. He stated he was given job descriptions to review at that time, as well. He approved the jobs of slinger, groundsman, and general longshoreman because most of the arm use required was handling eight pound twist locks. He approved the jobs of ship foreman and dock foreman because there did not seem to be any significant arm use.

Dr. Cohn reported that the Claimant's March 7, 2005, ultrasound report showed tendonitis in the biceps tendon, early arthritis in the glenohumeral joint, and inflammation in the subdeltoid bursa. He explained that there was swelling and possibly fluid in the bursa between the rotator cuff and bone above it, inflammation in the acromioclavicular joint, and a rotator cuff tear. There was also subacromial impingement, which he described as bone spurs or "bony prominences pushing on the rotator cuff area in the bursa." He stated that the ultrasound did not reveal anything about the Claimant's physical capabilities. Based on his review of the ultrasound, the FCE, and his examination, he stated that he still would have approved the above jobs because a person with a full-thickness tear should be able to use his arm at his side.

After reviewing the MRI of March 15, 2005, Dr. Cohn testified that there was no recurrent full-thickness rotator cuff tear. He confirmed that the Claimant had a second surgery on May 5, 2005, and he described the surgery. He stated that the Claimant's diagnosis of a retear of the rotator cuff meant that either his rotator cuff had not fully healed after the first surgery or it tore again, but it was only a partial tear. He reported that a doctor cannot tell whether a retear is from the previous injury or if it is new, but repaired rotator cuff tears do not always completely heal, so the Claimant's was most likely left from his prior injury. The diagnosis of acromioclavicular joint damage, he stated, likely meant that the Claimant had arthritis, based on the operative note. He reported that arthritis is the "wearing away of the smooth surface in a joint" and Dr. Wardell removed the end of the collarbone, which is how arthritis is treated in that joint.

Dr. Cohn reported that he saw the Claimant again on August 17, 2005, after he had undergone a subacromial steroid injection, which did not help, and the second surgery. He stated that the Claimant complained of pain on the top of his right shoulder that radiated into his neck and head and into his forehead, which Dr. Cohn stated is not typical for a rotator cuff problem. With a rotator cuff injury, Dr. Cohn testified he expected complaints of pain on the side of the shoulder with some radiation approximately halfway to the elbow. He stated that he has never had a patient complain about forehead pain with a rotator cuff tear and he could not explain it anatomically. He reported that a person with arthritis in the acromioclavicular joint will usually complain of pain over the shoulder and sometimes into the trapezius. At the examination, Dr. Cohn reported, the Claimant also refused to move his arm more than twenty degrees because of pain. He testified that the Claimant's neurological examination was mostly normal and he did not see any signs of atrophy, which is a decrease in muscle size due to neurologic injury or disuse because of pain. He further testified that absence of atrophy indicates that the person is using the extremity as much as the other and has good strength. At that time, he opined that the Claimant should not return to longshore work because of pain complaints and "psychological overlay." He explained that "psychological overlay" means that he could not attribute the Claimant's symptoms to an anatomic problem.

After review of the September 8, 2005, FCE, Dr. Cohn testified that the therapist's findings were consistent with his findings in August with respect to the Claimant's complaints of pain and symptoms not usually associated with a rotator cuff problem and complaints of significantly more pain than expected based on his injury. Dr. Cohn stated that he also reviewed a copy of the surveillance video that the therapist viewed on September 22, 2005, and he examined the Claimant that same day, although he did not know if he reviewed the video before or after. He testified as to the opinion letter he wrote about the first video and stated that, although he did not specifically remember what as shown on each video, he noted that on both, the Claimant "was using his arm at times much more comfortably than when he presented to the office."

Dr. Cohn testified that he had a copy of EX 37, which is a letter from Dr. Pellegrino, which indicated that the Claimant had no cognitive deficits that could be attributed to his injury. He stated that he did not note whether the Claimant ever told him he had cognitive problems because of his injury.

On November 30, 2005, Dr. Cohn stated, he saw the Claimant again. He testified that he was asked to give the Claimant a rating and to determine whether the Claimant's second surgery was appropriate, whether the Claimant needed work restrictions, and whether he would approve a hustler diver job. He stated that he gave the Claimant a sixteen percent rating for the right upper extremity using the Fifth Edition of the AMA Guides. He reported that he uses objective measurements whenever possible to determine ratings, so for the distal clavicle resection, he gave the Claimant a ten percent impairment. Then, he gave the Claimant a seven percent impairment for decreased range of motion based on a combination of his examination,[17] during which he measured the Claimant's right shoulder range of motion, and his expectations for a post-operative rotator cuff repair patient. He reported that he filled out a work restriction form and also testified as to the jobs he approved, which were groundsman, winchman, and slinger. He stated that he did not answer whether the Claimant could perform the hustler driver job at that time and requested an FCE on that question. However, he testified that on December 5, 2005, he approved the hustler driver job based on the Claimant's physical problem, surgery, objective findings, and surveillance film. He further testified that, based on his review of the second surveillance video on March 22, 2006, his opinion was that the Claimant could drive a hustler and could perform the other positions he had previously approved.

Dr. Cohn stated that he had read Dr. Wardell's physician's assistant's note of December 16, 2005, instructing the Claimant not to use his arm at work, but to use it at home in any manner. He testified that his did not understand the note because "I would not prohibit someone from doing things at work that he also does at home."

On cross-examination, Dr. Cohn testified that the first FCE recommended a trial return to work as a groundsman, slinger, top loader, operator, or hustler driver, but the examiner did not recommend he return to his regular job of lasher. He also testified that Ms. Harwell sent him a letter which stated that the Claimant's prior job was as a lasher and described his work injury. He reported that the Claimant had returned to work as a hustler driver before his first appointment, but stopped because he could not stand the pain.

Dr. Cohn reported that he first saw the Claimant on March 1, 2005, after the first surgery, which he confirmed was both arthroscopic and open surgery. He agreed that on the basis of the MRI performed before that surgery, he would have recommended it. He stated that when he saw the Claimant, he was on hydrocodone, which he told Dr. Cohn made him drowsy. The Claimant complained that reaching hurt and also complained of pain over the deltoid region, which Dr. Cohn testified people with rotator cuff injuries often experience. Dr. Cohn stated that people with rotator cuff injuries also hold their arm close to their body in a protective fashion, much like the Claimant did at that visit. He reported that he would not allow the Claimant to perform a job where he had to drive, use his arm overhead, or lift a significant amount of weight, and confirmed that driving jobs included forklifts and hustlers.

Dr. Cohn testified that tendinosis is when the tendon is damaged and shows signs of prior inflammation, which is different than tendonitis, which means the tendon is currently inflamed. He reported that an MRI before the Claimant's surgery showed subluxation of the humeral head,

[17] On examination, the Claimant was able to elevate his left arm to 150 degrees, and the report stated that he could elevate his right arm to 190 degrees, but Dr. Cohn stated that it should be ninety degrees.

which means that the ball of the shoulder is off the back of the cup part of the shoulder. He did not know why that would be significant, but stated that repairing the cuff and restoring strength and muscle balance could correct the subluxation. He stated that he thought the MRI after surgery did not show any subluxation. Dr. Cohn explained that when he stated that the end of the anchor was proud in relation to the bone, he meant that it appeared from the x-ray that the anchor was not screwed far enough into the bone, which may have caused some symptoms when the Claimant raised his arm. He stated that he recommended the Claimant have a subacromial injection and then an MRI to see if the rotator cuff had healed. He testified that if he had had the results of the ultrasound and of the MRI performed on March 15, 2005, at the March 1 visit, he still would have recommended the injection first and then made a decision as to a second surgery based on the results of the injection. If the injection had stopped the Claimant's pain, he stated, a second surgery had a "reasonable chance of helping."

The Claimant's ultrasound, Dr. Cohn reported, showed a full-thickness tear, but the MRI only showed a partial tear. He conceded that the only way to know for sure which was correct was to perform the surgery, but testified that he would rely more on the MRI, not the ultrasound, as he did not know the ultrasound's accuracy. Based on that MRI alone, he testified that he would not have recommended a second surgery and with the MRI results and a negative injection test, he also "would not necessarily recommend surgery." Since he did not know the results of the injection test, he could not say if the second surgery was indicated, but he stated that it was reasonable.

Dr. Cohn testified that without knowing whether the Claimant had a full-thickness or partial thickness tear, he would base a return to work on the Claimant's symptoms, what the doctor thought was wrong, and the job. He stood by his decision to approve some of the jobs presented to him on March 1, 2005, reporting that he has other patients waiting for rotator cuff repair that are also still working. He also stated that he stood by the other things he wrote in his report of March 1, based on what he knew at the time. He confirmed that he had disapproved jobs as a lasher, forklift operator, hustler driver, toploader/reach stacker operator, gangwayman, and line handler. He also confirmed that he approved the jobs of general longshoreman, groundsman, dock foreman, and slinger based on the descriptions provided.

During the second surgery, part of the distal clavicle was excised, Dr. Cohn stated, to treat the Claimant's arthritis, which was felt to be causing some of his pain. He reported that after this surgery, the anchor was still slightly proud according to x-rays. He testified that when he saw the Claimant on August 17, 2005, which was after the second surgery, the Claimant was upset and told him he did not want any more surgery. Dr. Cohn further testified that he suspected the Claimant was depressed, so he suggested the Claimant's pain management specialist evaluate him for depression. He stated that he also recommended the Claimant use aqua therapy instead of regular physical therapy. He could not recall if the Claimant had told him regular physical therapy hurt, but he opined that the thought it just would not do any good because it did not seem to be working up to that point. Dr. Cohn testified that he maintained the same opinion at the deposition that he had on August 17, 2005, which was that the Claimant should not return to longshore work because of pain complaints and psychological overlay, not because of the physical problem with his shoulder. He agreed that he recommended the Claimant see pain management and psychological specialists, and Dr. Mingione filled those roles.

With regard to the surveillance video referenced in his September 22, 2005, report, Dr. Cohn testified that he watched the entire video before writing the report. He did not know how long the video was and did not recall how many days the video covered.

Dr. Cohn stated that, prior to his November 30, 2005, examination, he received a report showing that the Claimant was found to be functionally illiterate and possibly borderline mentally retarded. When he saw the Claimant on November 30, the Claimant was receiving Mobic, which is an anti-inflammatory medication, oxycodone, and Lunesta, a sleeping pill, from Dr. Mingione. He stated that the Claimant complained of occasional sharp pain that caused him to worry and protect his arm and reported that he has had patients in the past who protect an injury to avoid pain. He opined that the Claimant's guarding actions did not explain all of his symptomology.

When discussing his November 30, 2005, report, Dr. Cohn agreed that he thought the May 5, 2005, surgery was appropriate. He also agreed that, because of the Claimant's pain and/or apprehension, he was unable to get accurate range of motion or strength measurements. He stated that he normally uses range of motion and strength findings, but sometimes he uses other things as well. However, he stated, he prefers to rely on range of motion and diagnosis-based measurements because they are more accurate. In this case, he stated, he did not exclusively use the Claimant's actual range of motion. He used the fact that the Claimant could move his arm at least ninety degrees based on the examination and noted that from the videos, he had other range of motion. He testified that he did not note the exact range of motion he used, but the rating he gave the Claimant is typical for someone who underwent rotator cuff surgery. He reported that he assigned the seven percent impairment due to decreased range of motion based on what normal elevation, external rotation, internal rotation, abduction, and adduction would be after a rotator cuff repair. He could not, in a reliable way, measure the Claimant's elevation, external and internal rotation, abduction or adduction. He did not use strength, crepitus, sensory deficit, pain, or instability measurements for the impairment rating. He confirmed that he gave the Claimant a ten percent impairment rating based on his distal clavicle resection.

Dr. Cohn testified that Mr. Schall's findings regarding the Claimant's range of motion during the September 8, 2005, FCE were not consistent with the range of motion findings he made on November 30, 2005, the date he gave his permanency evaluation. He stated that he usually found Mr. Schall's evaluations to be accurate. Passive motion is generally greater than active motion, Dr. Cohn reported, and the Claimant actively raised his arm further at the office than Mr. Schall could passively raise it during the FCE. He credited Mr. Schall's report that the Claimant's shoulder audibly popped when Mr. Schall tried to move it, but he did not recall ever hearing one when attempting to move the Claimant's shoulder and he did not know what it indicated. He stated that Mr. Schall's report did not change his opinion from November 30, 2005, and he was not sure if Mr. Schall's opinion was consistent with his.

Dr. Cohn then testified regarding the work restrictions he placed on the Claimant on November 30, 2005, which are set out above. He confirmed that he approved the jobs of groundsman and general longshoreman, but stated that he would reconsider if the Claimant had to use his right arm away from his body for two hours a day. He also confirmed that he did not approve the following jobs: lasher; gearman; line handler; gangwayman; transtainer; forklift operator; and

hustler driver. He testified that he asked Mr. Schall to perform an FCE with regard to the hustler driver job and that he would take it into consideration. He then reported the contents of Mr. Schall's December 23, 2005, letter, which is discussed below. He stated that that Mr. Schall did not approve or disapprove the job, but recommended, based on the Claimant's demonstrated physical capacities, that the Claimant not drive a hustler.

With respect to the jobs he did approve on November 30, 2005, Dr. Cohn testified that he expected the Claimant to be able to do the jobs even if he still had some symptoms from his rotator cuff tear, because the repaired tear does not always become asymptomatic. However, he stated that with the amount and type of symptoms the Claimant was experiencing, the Claimant did not appear to be able to do the jobs. He could not tell if the symptoms the Claimant was experiencing were work-related or not. His opinion was that they were not due to the rotator cuff tear, but he did not know what they were due to. He testified that he could not call the Claimant a malingerer, or someone "who is intentionally exaggerating his symptoms for gain."

Dr. Cohn testified that the Claimant came to his office on January 31, 2006, but he did not think the Claimant had an appointment. He did not examine the Claimant on that date, but the Claimant told him he could not elevate his arm more than ninety degrees. He testified that he had not seen the Claimant since that date. He also testified that on June 1, 2006, he disapproved the light duty painter/power washer job description.

The Claimant's counsel showed Dr. Cohn the note of August 16, 2006, where Dr. Mingione noted that the Claimant thought he needed another surgery. Dr. Cohn testified that he would not recommend another MRI to see if another surgery was necessary because of his other issues. He stated that an MRI would not hurt, but he would not perform surgery on the Claimant until he was cleared by pain management and told that the Claimant's symptoms were organic and stemming from his shoulder.

On redirect examination, Dr. Cohn testified that he had a description for the hustler driver job and that on December 5, 2005, he wrote a letter to the Employer's counsel which indicated that he would approve that job. He opined that, based on a work-related rotator cuff tear that had been surgically repaired, he would still allow the Claimant to drive a hustler. He testified that when he allows a person back to work on a trial basis, it means he is not sure the job will work out for that person. He stated that the person is not released from his care, so they can return after attempting the job to discuss how it worked out.

Dr. Cohn stated that, when he notes that something is "history," he means that the information was given to him by the patient or he read it in a report, but he does not always adopt it. He also stated that when he examines someone several times, he either accepts the person's subjective complaints or does not. With the Claimant, he stated, he did not discount his complaints of pain, but based on the work injury, he could not explain the Claimant's symptoms. He repeated that the Claimant's actions on the surveillance tape, how he presents, and how he describes his condition are inconsistent. Dr. Cohn testified that, although he cannot say the Claimant is malingering, he cannot rule it out, either.

With respect to Mr. Schall's assessment that the Claimant did not demonstrate the physical capacity to perform the hustler driver job, Dr. Cohn testified that he understood it to mean that Mr. Schall observed pain behaviors and based on his objective observations while the Claimant was driving, he would not suggest the Claimant drive a hustler. He reported that pain behaviors are "symptoms not related to the anatomic problem." He stated that, while not an expert in pain behaviors, he supposed they could be exaggerated.

Dr. Cohn testified that active range of motion is when the action is performed by the patient, while passive range of motion is when someone performs the action for the patient. He stated that the Claimant's range of motion on the surveillance video was different than the active and passive ranges of motion shown on examination. He testified that the opinions he gave in his March 22, 2006, report were his current opinions.

On recross examination, Dr. Cohn testified that his signature was on the November 30, 2005, hustler driver job description. On further redirect examination, Dr. Cohn stated that, when he disapproved the hustler driver description, he did not think he had seen the second surveillance video yet, but he was not sure. He testified that when he cleared the Claimant to drive a hustler on December 5, he based it on all the information he had at that time. On further recross examination, Dr. Cohn testified that he watched all of each surveillance video and he only watched each one time. He could not remember when he watched the videos. On further redirect examination, Dr. Cohn repeated that he watched each video at least once, but he doubted he watched them more.

Dr. P. Mansheim, M.D. – Curriculum Vitae (EX 36); Medical Reports (EX 33, 44); Deposition (CX 4; EX 65)

EX 36 contains Dr. Mansheim's curriculum vitae. Dr. Mansheim received his M.D. from the University of Wisconsin Medical School. He is currently in private practice and is the Medical Director of Tricare Region 1. He is certified by the American Board of Psychiatry and Neurology in General Psychiatry, Child Psychiatry, and Psychiatry with added qualifications in Addiction and Forensic Psychiatry. He is also certified by the American Board of Forensic Psychiatry.

EX 33 contains the independent medical evaluation report Dr. Mansheim wrote after reviewing the Claimant's medical records and conducting a one-hour interview of the Claimant on October 20, 2005. On examination, the Claimant reported that he had not worked since July 7, 2004, when he was injured after a shipmate knocked down a lashing rod, which fell and hit him on the head and right shoulder. He reported that the impact nearly knocked him off the ship and that he lost consciousness. He injured his shoulder and has had two surgeries, but still experiences pain. He also reported severe headaches and sleeping problems.

The Claimant reported that he had worked for the Employer and held a G card. He reported that he made $28.00 per hour of straight-time, although any work after 5:00 p.m. was paid at time-and-a-half. He claimed that he could easily make $100,000.00 per year when he worked full time, but he is now getting only $48,000.00 per year in workers' compensation. He stated that he hoped to go back to work, but he cannot because he cannot use his right shoulder much. He

told Dr. Mansheim that he is right-handed, but he cannot pick anything up because of the pain in his right arm. He said he could return to work if his shoulder and arm were fixed.

The Claimant told Dr. Mansheim that Dr. Wardell is his orthopedic surgeon and his physical therapist is named Greg. He reported that Dr. Wardell and Greg said "his arm will never be right." He could not remember when he stopped physical therapy, but he knew he stopped because it made him worse. The Claimant reported that he also saw Dr. Mingione monthly, and got oxycodone for pain, Zetril for hypertension, and Lunesta for sleep.

With respect to his personal life, the Claimant told Dr. Mansheim that he lived with his second wife, whom he had been married to for eight months, and that he had four children from his first marriage and four other children by three other women. All his children are adults.

The Claimant reported that he left school in first grade because a girl in his class accused him of stealing a quarter from her and he was ashamed. He stated that he never learned to read well, but he wanted to learn to read the Bible. He also reported that he had a tutor. The Claimant told Dr. Mansheim that his only real problem is his shoulder and that he does not have memory problems. He stated that all he does is stay home and go to doctor's appointments.

Dr. Mansheim diagnosed the Claimant with functional illiteracy and opined that his inability to interpret proverbs well on examination by Dr. Gerstle is consistent with that diagnosis. He stated that there was no indication that Dr. Mingione was aware of the Claimant's functional illiteracy or that he took it into account when diagnosing the Claimant with cognitive problems. He also stated that Dr. Gerstle's opinion that the Claimant was mildly mentally retarded based on his intelligence testing may have been influenced by a mistaken impression that the Claimant was a high school graduate. He reported that "[a]n individual who is functionally illiterate is not going to be able to do very well on an intelligence test, because a great deal of the material on an intelligence test is affected by education levels." Dr. Mansheim opined that "there is no indication that [the Claimant] has cognitive impairment or a psychiatric condition as a result of a work-related injury. In my opinion, the findings are consistent of an individual who is functionally illiterate."

Dr. Mansheim stated that the fact that the Claimant was oriented and had adequate short-term memory when he was examined by Dr. Gerstle and Dr. Pellegrino indicated that he does not suffer from dementia. He opined that "there is absolutely no indication that [the Claimant] has dementia. If he did have dementia, there is no indication that his work-related injury was of such a nature as to be likely to cause dementia." Finally, he opined that "there is no evidence that [the Claimant] has a psychiatric condition which was occasioned by a July 06, 2004 work-related injury."

EX 44 is a letter from Dr. Mansheim, written on December 16, 2005, after review of the August 8-9, 2005, surveillance video, Dr. Cohn's report of September 22, 2005, and Mr. Schall's report of the same date. Dr. Mansheim reported that Dr. Cohn suggested that maybe the Claimant had an emotional state that is better at times and worse at others, which would explain his tearfulness and emotional upset in the office but apparent ease of use of his right arm on the video. However, Dr. Mansheim opined that "there is no psychiatric disorder which would explain why

somebody would be able to use his right hand and arm better at some times than at other times. In my opinion, from a psychiatric point of view, the only reasonable explanation is malingering."

Dr. Mansheim reported that the Claimant did not appear to have problems operating the motor vehicle in the video, which conflicts with Dr. Mingione's assessment that he should not operate a vehicle. He noted that the Claimant did not appear to be particularly uncomfortable using his right hand when shown holding an umbrella, swinging his arm in a normal fashion, lifting his arm over his shoulder to close the trunk of a vehicle, or carrying what looked to be a one-liter bottle. He opined that "the images on the video tape are consistent with the idea that [the Claimant] has much better ability to use his right arm than he would like others to believe."

EX 58 contains a medical report dated January 20, 2006, from Dr. Mansheim following a one-hour independent medical examination of the Claimant and review of additional records that were not available to him at the prior examination. On examination, the Claimant complained mainly of right shoulder pain and that he "hasn't been right since the surgery." He told Dr. Mansheim that he had been taking OxyContin, but it was changed to Tramadol, which is also known as Ultram, and then to Darvocet. He stated that he had not gotten the Darvocet yet because Dr. Mingione had just prescribed it the day before. He reported that he had a few oxycodone tablets left that he used when needed, which included a tablet that morning. When asked about other medications, the Claimant was unable to give a list, but his wife reported that he was taking Darvocet, Mobic, hydrochlorothiazide, and Lunesta.

Dr. Mansheim met with the Claimant to evaluate his cognitive functioning using the Folstein Mini-Mental State examination. He reported that the Claimant took a long time to complete the tasks. The Claimant scored five out of five on the first two sets of orientation questions and scored three out of three on the third set of questions, which related to the ability to remember three objects and repeat them. The fourth set of questions related to concentration. Dr. Mansheim asked the Claimant to subtract 7 from 100 in serial fashion until he reached 65, which the Claimant was able to do, although it took a long time. He chose not to have the Claimant spell the word "world" backward because he did not think the Claimant could. He noted that the Claimant later told him he could write and read his own name, but could not do more reading or writing than that.

The next activity was to name the three objects from the third set of questions. The Claimant had a great deal of difficulty and at first did not remember that Dr. Mansheim had told him three objects. Dr. Mansheim did the test again with three different objects, which he showed the Claimant, who was able to repeat the objects several minutes later. The Claimant received two out of two points on the next portion, which was to name two objects Dr. Mansheim pointed to, those objects being a watch and a pen. He did not get credit for the next section, which was to repeat the phrase "no ifs, ands, or buts." He got two out of three possible points for the following portion, which consisted of a three-stage command. Dr. Mansheim instructed the Claimant to take a piece of paper in his left hand, fold it in half, and put it on the floor. The Claimant got two points for taking the paper in his left hand and placing it on the floor, but he lost the third point for folding the paper four times instead of in half.

The last section of the test was to carry out written commands, which were to read his name after Dr. Mansheim wrote it, write his name, and copy a design. He did all three without problem. Dr. Mansheim noted that the Claimant missed only two points on the entire examination. He opined that "this is not indicative of dementia. Dementia is suspected if an individual misses five to ten points or more."

Dr. Mansheim stated that taking Darvocet would not likely cause the Claimant to have a "specific psychiatric or psychological condition which would prevent him from working or from doing anything else for which he is well qualified, given medical limitations, by virtue of education, training, and experience." He reported that the Claimant's drug screen came back positive for oxycodone, but he did not find that the Claimant's "mental abilities were impaired on a day in which he had a positive urine drug screen for Oxycodone." He opined that "it is not unreasonable for [the Claimant] to see a doctor for once monthly brief medication management visits in order to have treatment for pain." Since Dr. Mingione's records showed the Claimant was being treated for pain complaints, his treatment was reasonable and necessary. He also opined that "there is no present indication that [the Claimant] has difficulties in cognitive function, as a result of taking pain medication, which prevents him from performing any work-related activity for which he is reasonably well qualified, given medical limitations, by virtue of education, training, and experience."

CX 4 and EX 65 contain copies of the transcript of Dr. Mansheim's October 6, 2006, deposition. Dr. Mansheim testified that he graduated from the University of Wisconsin Medical School in 1971 and did his internship, general psychiatry residency, and child psychiatry fellowship at the University of Wisconsin Hospitals. He testified that he is Board-certified in Psychiatry, Child Psychiatry, Forensic Psychiatry, and Addiction and Forensic Psychiatry by the American Board of Psychiatry and Neurology.

For his October 20, 2005, report, Dr. Mansheim testified that he examined the Claimant and reviewed medical records from Drs. Wardell, Cohn, Mingione, Gerstle, and Pellegrino. He stated that, from a psychiatric point of view, he determined that the Claimant had increasing central nervous system complaints as time went on. He agreed that Dr. Mingione found some cognitive problems in August of 2005 and told the Claimant not to drive. Dr. Mansheim testified that there was no reasonable explanation as to why someone would develop cognitive problems a year after injuring his arm and shoulder. He further testified that, even if something had hit the Claimant on the head, there was no explanation as to why it would take a year for symptoms to appear. He also had no explanation as to how the symptoms could disappear shortly after manifestation.

Dr. Mansheim reported that he determined the Claimant did not have a psychiatric disorder as the result of a work-related condition. He stated that the basis for his conclusion was that he did not find any symptoms that added up to a psychiatric disorder.

Dr. Mansheim testified that, if Dr. Gerstle had accepted the Claimant's report that he graduated from high school, he would have had to wonder how he did so or if something had happened that would explain the significant decrease in intellectual functioning, since his IQ test scores were so low. Dr. Mansheim testified that the IQ score would be misleading if the Claimant had left

school in first grade, which is what he reported to him. He stated that mental retardation is not having a low IQ, it is "having intellectual functioning two standard deviations below the mean originating in the developmental period and associated with adaptive deficits." He testified that the Claimant does not appear to have adaptive defects, as he is capable of doing the things he needs to do. He stated that the numbers Dr. Gerstle's testing revealed are misleading because they do not show the Claimant's true intelligence.

If the Claimant was functionally illiterate, Dr. Mansheim stated, he would expect the Claimant's scores to be below average. He also stated that a person can be functionally illiterate and still have a high IQ. He did not know how to test a functionally illiterate person's IQ accurately, but suggested that a Peabody Picture Vocabulary Test, which does not have words, could be administered. He stated that the tester would have to know that the person did not have much education and find a way to test nonverbally if possible.

Dr. Mansheim discussed his December 16, 2005, report, in which he reviewed the surveillance tapes of August 8-9, 2005. He stated that he opined the Claimant was malingering "because if a person is able to do something much better than he represents that he can do it, then the only reasonable explanation is malingering." He defined malingering as "the conscious presentation of symptoms."

Dr. Mansheim testified that he reviewed a second surveillance video, which showed the Claimant wearing a sling, although when he appeared to be in private, such as on the balcony of his apartment, he did not wear it. He stated the Claimant appeared to be able to motion with his right hand and lift his right hand over his head with no difficulty and he opened a van door with his right arm with no great discomfort. He also stated that the Claimant still used his arm while in the sling. He reported that the Claimant waved his right hand in the air for a significant period of time and that there were times on the video where the Claimant would freely move his arm, but later the same day would wear the sling. Dr. Mansheim opined that "[t]he only reasonable explanation is that when he's in public, he wears the sling so that everybody can see that he has the sling, and when he's in private, he takes it off because, after all, he doesn't really need it." He stated that there was no consistency in the Claimant's actions and concluded that he "has significantly more function in his right arm and shoulder than he would want everyone to believe." He confirmed that he would still say the Claimant is malingering.

With regard to his second evaluation, Dr. Mansheim reported that he reviewed more medical records from Drs. Cohn, Mingione, and Wardell, a videotape, and a urine drug screen, and performed an examination. He reported that he used the Folstein Mini-Mental examination to assess the Claimant's mental status. He stated that it took a very long time because the Claimant appeared very unenthusiastic about answering the questions, but he was well-oriented and the results showed that he did not have dementia. Dr. Mansheim also stated that he did not find evidence that oxycodone was significantly affecting the Claimant's cognitive function.

Dr. Mansheim testified that he did not treat or evaluate pain in his practice, although as a forensic psychiatrist, he would sometimes have to assess the extent to which pain interferes with a person's functioning and to which the person is exaggerating pain. He stated that he was not in a position to say the Claimant was malingering with respect to pain and that his reference to

malingering was with respect to the Claimant's functioning. There is a difference, he stated, between someone who has a lot of pain but is still very active, and someone who is in less pain but lets it dominate their life. He testified that to determine the Claimant's ability to work, he would go by the Claimant's ability to function as demonstrated objectively. In psychiatry, he stated, doctors look for corroborative objective signs of the psychiatric symptoms a patient complains of and that psychiatrically, he did not find any symptoms precluding the Claimant from doing any kind of job he was reasonably well-qualified for by education, training, and experience. He stated that he did not think the Claimant had a cognitive problem, which was the only "quasi-psychiatric" aspect of his situation.

On cross-examination, Dr. Mansheim reported that he did not have Dr. Wardell's January 11, 2006, note in his file before he saw the Claimant six days later. The Claimant's counsel gave him a copy to review, which was marked as Exhibit 1 for deposition purposes. Dr. Mansheim testified the note showed that on January 11, 2006, the Claimant reported good results from a subdeltoid injection on December 27, 2005, and that Dr. Wardell recommended another. He was unable to say whether the relief from the first injection extended into the period when the second surveillance video was shot or whether the Claimant had gotten another injection beforehand. He stated that, even if the injections helped the Claimant's pain, it would not explain all the inconsistency on the video, although it would explain some of his ability to move his arm and shoulder.

Dr. Mansheim reported that he saw the Claimant on October 20, 2005, for a mental status examination and in particular to determine whether the Claimant had a psychiatric disorder as a result of a work-related condition. He stated that he did not physically examine the Claimant, so the orthopedists have most of the say regarding the Claimant's complaints of pain and physical findings. However, since Dr. Cohn did not have any orthopedic explanation for the difference between what the Claimant was demonstrating and what he was capable of, he deferred to Dr. Mansheim to determine if there was a psychiatric disorder that would explain it. Dr. Mansheim testified that making a quasi-objective assessment of a person's level of functioning and whether the person is exaggerating symptoms is part of assessing a psychiatric disorder. He stated that any idea he has about whether the Claimant is exaggerating is based on the surveillance videos and the FCE.

Dr. Mansheim agreed that Dr. Mingione's referral to Dr. Pellegrino was appropriate and that both physicians were well-regarded in the community. A portion of Dr. Pellegrino's report was read into the record, including the portion where he ruled out chronic regional pain syndrome ("CRPS"). Dr. Mansheim testified that, as a primary care physician, he has never treated a patient with CRPS, but he had seen patients with CRPS.

Dr. Mansheim stated that he generally examines a patient first and then reads the medical records. He testified that he was sure he did so in this case with the exception of the surveillance video, which he did not review until mid-December of 2005, after he saw the Claimant. He then testified regarding the contents of his October 20, 2005, report, which was based on the Claimant's first visit and his first record review. He stated that the Claimant told him that he could not work because he did not have much use of his right shoulder, but hoped he could return to work. After review of the September 8, 2005, FCE, Dr. Mansheim stated that Mr.

Schall opined that the Claimant did not qualify for any job as a longshoreman. He reported that Dr. Mingione's records indicated high levels of anxiety, tension, and dysphoria, which is "[f]eeling sad." He agreed that Dr. Pellegrino assessed chronic right upper extremity pain. At the Claimant's counsel's prompting, he read Dr. Cohn's assessment of the Claimant's ability to work as a longshoreman and agreed that Dr. Cohn recommended the Claimant see a pain management specialist and a psychologist or psychiatrist. He stated that it was reasonable for Dr. Mingione to be the Claimant's treating psychiatrist, as he is a psychiatrist as well as a pain management specialist. He was aware that Dr. Mingione had instructed the Claimant not to drive, but did not remember seeing a note that the Claimant was released to drive.

GAF, Dr. Mansheim testified, is the global assessment of functioning, which is a scale from one to 100, with 100 being perfect and one being "hardly conscious," used to measure a person's level of functioning. He stated that a GAF of 59 means the person has significant symptoms with work, family, or social relationships and is typical for psychiatric outpatients. He later testified that he gave the Claimant a GAF of 80 "as a specific result of an Axis I psychiatric disorder." He stated that he tries to restrict his determination of GAF to psychiatric symptoms because he views the GAF as a psychiatric assessment, not a physical assessment.

At the request of the Employer's counsel, Dr. Mansheim reported, he saw the Claimant a second time for a formal assessment of the Claimant's mental state and a determination of whether there was any psychiatric effect on the Claimant from opiate medication. He also was to determine whether Dr. Mingione's treatment was reasonable and necessary. He stated that he tested the Claimant for OxyContin[18] at his second examination and the Claimant tested positive. He agreed that OxyContin sometimes causes drowsiness, as it is a narcotic. He also testified regarding some of the contents of the medical report with regard to his review of Dr. Cohn and Dr. Mingione's medical records. He stated that when Dr. Cohn referenced the Claimant's "mental condition," he assumed Dr. Cohn meant his psychiatric condition, not his pain.

Dr. Mansheim testified that he was unaware of the opinions expressed by Drs. Wardell and Mingione in their respective depositions. He stated that he hoped they would be in a position to assess the reliability of the Claimant's pain, since each had seen him so many times. The Claimant's counsel then read portions of Dr. Wardell's deposition into the record. Dr. Mansheim testified that, unlike Dr. Wardell, he was not talking about the Claimant faking his pain, but his level of functioning. The Claimant's counsel also read portions of Dr. Mingione's deposition into the record. Dr. Mansheim confirmed that he knew Dr. Mingione had diagnosed the Claimant with depression. With regard to Dr. Mingione's opinion that the Claimant was not bright enough to malinger, Dr. Mansheim stated:

> I disagree completely that this man is not bright enough to malinger. I think this is a very bright guy. It's a man with a first-grade education who is driving around in a late-model BMW and a big recreational vehicle . . . You can't function to be able to do stuff like that unless you have some intelligence. He's a bright man. I found him to be very bright when I talked with him. He's just not very verbal.

[18] OxyContin is another name for oxycodone.

Dr. Mansheim also stated that he did not agree with Dr. Mingione's diagnosis of depression and pointed out that the Claimant was not consistently taking antidepressants while in treatment with Dr. Mingione. Crying and sadness, Dr. Mansheim testified, are symptoms associated with depression, but confusion is not often a symptom and is not really considered when screening for depression. He also testified that pain and headache are not symptoms of depression. However, he testified that if the Claimant was depressed and had pain, it would be reasonable to determine that pain caused some depression.

Dr. Mansheim testified that, in his December 16, 2005, report, he stated that he did not agree with Dr. Cohn's suggestion that the Claimant had an emotional state that was better at times and worse at others. He also testified that Dr. Cohn also raised the question of whether the Claimant was depressed in his August 17, 2005, report. He stated that he was unaware of the opinions Dr. Cohn gave during his deposition, so the Claimant's counsel read portions of that deposition into the record. Dr. Mansheim testified that he did not agree with Dr. Cohn's opinion that the Claimant had psychological overlay preventing him from returning to work as a longshoreman. He opined that there is no good evidence that the Claimant has a psychiatric disorder as a result of a work-related condition that is preventing him from returning to work and there is a lot of evidence that shows the Claimant has less pain than he claims to have. He also testified that while Dr. Cohn stated that he could not say the Claimant was a malingerer, it does not mean he does not think the Claimant is malingering. He stated that, by the way Dr. Cohn answered, it appeared he was deferring because he was unable to answer the question.

With regard to Dr. Mingione's August 16, 2006, report, Dr. Mansheim testified that he had received it and it quoted the Claimant as telling Dr. Mingione he thought he needed more surgery. He recalled that the Claimant cried when he spoke to Dr. Cohn about another surgery. He stated that he would not conclude that the Claimant was not having pain.

Dr. Mansheim stated that he viewed the first surveillance video sometime in the middle of December of 2005 and the second surveillance video the weekend before his deposition. He estimated the first video to be about one hour and nineteen minutes long and the second video to be about forty to fifty minutes. He testified that he did not remember whether in the first video the Claimant was swinging his right or left arm more while walking, but later stated he remembered the Claimant swung both arms in a normal fashion at times. He did not recall anyone telling him that Dr. Mingione had viewed the first video and he did not know what Dr. Mingione meant when he stated that "[i]t is impossible to infer whether any of the movements seen on the video were performed with the experience of pain." He stated that he thought the point of the video was not to determine the level of pain the Claimant was experiencing, but to determine the Claimant's level of functioning. He stated that it is possible to tell if the person is in pain during certain activities if the person grimaces, guards the limb, or does not use the limb.

Dr. Mansheim stated that he never received Dr. Cohn's December 5, 2005, report about the surveillance video, so counsel read a portion of that report into the record. He testified that he agreed with Dr. Cohn's statement that the Claimant did not use his arm in a repetitive fashion, but only used it to close his car trunk once.

The Claimant's counsel then asked Dr. Mansheim whether he remembered certain portions of the first surveillance video. Dr. Mansheim did not recall the Claimant dozing in his van with his head leaning against his left hand. He recalled the Claimant driving his van and using his left arm and hand to turn the wheel, but did not recall which hand the Claimant used to open his car door. He also recalled the Claimant at a service station opening the gas cap of a car with his right hand, but did not recall anything about a can of oil or petroleum. He did not specifically remember the Claimant closing his trunk with his left arm the first time. He also did not remember what hand the Claimant held his umbrella in while entering and exiting a building.

The Claimant's counsel asked Dr. Mansheim whether he remembered specific portions of the second surveillance video as well. Dr. Mansheim noted that on January 31, 2006, the Claimant held his arm in a protective manner at his right side and that he reached for his coat with his left arm. He recalled that when the Claimant put his coat on, he did so with his left arm and did not put his right arm through the sleeve. He remembered that the Claimant also opened his car door with his left arm and carried a plastic bag with his left arm. He did not recall whether the Claimant swung his left arm more than his right while walking. Dr. Mansheim noted that on February 3, 2006, the Claimant was wearing his sling outside and he leaned over and shook a man's hand with his sling still on. He recalled that the Claimant opened his car door with his left hand and his right hand.

Dr. Mansheim testified that Dr. Gerstle tested the Claimant with the Wechsler Adult Intelligence Scale III, Third Edition. He stated that it is the most commonly used IQ test for adults.

On redirect examination, Dr. Mansheim testified that malingering is a psychiatric diagnosis. He reported that the term "psychological overlay" is slang meaning that the doctor thinks something psychiatric might be going on, but does not know what. He testified that he did not diagnose depression in the Claimant because he thought the Claimant was a "pretty high-functioning guy psychologically. . . . I didn't find him to be particularly psychiatrically impaired."

Dr. Mansheim testified that he limits his evaluations to function because he is not a pain management specialist and because when someone is out of work because of medical problems, he sees it as an issue of function, not discomfort. He also testified that there is a difference between pain and function. He stated that "pain is a subjective experience of discomfort, and some people can function very well even with very high levels of pain." He further stated that there is no way to know for sure whether pain is real and, although Dr. Mingione has an advantage by being one of the Claimant's treating physicians, he does not have a "special way" of knowing whether pain is real.

With regard to the FCE in which Mr. Schall stated that he could not find any physical pathology to account for the Claimant's complaints, Dr. Mansheim stated that Mr. Schall was saying that he could not find concrete evidence to account for the Claimant's complaints. He reported that Mr. Schall also stated that there was evidence to suggest a "behaviorally-based origin" to the complaints, which he interpreted to mean that Mr. Schall was not sure the Claimant was as disabled as he was making himself out to be.

Dr. Mansheim explained that what he meant when he stated that the Claimant's injection would not explain the inconsistencies on the surveillance video was that there is not enough information to determine that the improved function came from the injection when it was in late December of 2005, Dr. Mingione's report was on January 11, 2006, and the video was taken a few weeks afterward. He stated that there could have been other things between January 11 and the time the video was taken at the end of January through early February to change the Claimant's condition. He stated that he would have expected the Claimant to be consistently better if the injection was the cause of the change, but he was not on the video.

Dr. Mansheim testified that none of the documents he reviewed at the request of the Claimant's counsel changed his opinions.

On recross examination, Dr. Mansheim stated that he did not know if Dr. Cohn saw both surveillance videos, but he confirmed that Dr. Mingione only saw one video. He testified that he could not compare Dr. Mingione's January 11, 2006, note to the videos because there was more information on the videos than in the note. He did not know if the Claimant had any treatment after January 11, 2006, that either helped or hurt.

Dr. T. Pellegrino, M.D. – Medical Record Entry (CX 7; EX 27), Medical Report (EX 37)

CX 7 and EX 27 contain copies of a medical record entry by Dr. Pellegrino on August 2, 2005. The Claimant saw Dr. Pellegrino at the request of Dr. Wardell for neurological consultation for chronic right shoulder and arm pain and an abnormal MRI scan. He complained of chronic headaches, tingling and numbness in his right arm, problems with gait, memory problems, double vision and blurry vision, exertional dyspnea, sexual dysfunction, tension, anxiety, and stress. Dr. Pellegrino noted that the Claimant had two surgeries on his right rotator cuff, but he still had pain in his right shoulder, right arm, and the right side of his neck. He also noted that "[n]o specific structural lesion has been identified either by physical examination or by imaging studies to account for his pain." He further noted the Claimant's long history of hypertension.

On physical examination, the Claimant was in no apparent distress and his speech was "clear and well articulated," but he seemed confused about some of his history. His eye movements were normal and symmetrical. Dr. Pellegrino noted normal strength in the left upper and both lower extremities, but right upper extremity strength could not be determined because of pain in the shoulder and upper arm. However, his muscle bulk appeared normal with no evidence of atrophy. His grip strength also could not be tested, but there was no evidence of wasting or other change in the intrinsic muscles. The Claimant's coordination was normal in the left upper and both lower extremities, but the right upper extremity could not be assessed. He walked with a slightly wide-based gait, favoring the right side. His sensations and reflexes were normal. His MRI showed white matter lesions most consistent with small vessel ischemic disease.

Dr. Pellegrino opined that the Claimant "has chronic pain but there are no trophic changes or other changes in the extremity to suggest CRPD. . . . There doesn't appear to be any 'neurologic' injury affecting the right upper extremity." He further opined that the lesions on the MRI were not related to the Claimant's injury, nor were they causing any of his current symptoms. He did not think the Claimant needed further neurological evaluation.

EX 37 contains a copy of the November 28, 2005, medical report of Dr. Pellegrino, which was written after review of Dr. Gerstle's August 11, 2005, neuropsychological testing. Dr. Pellegrino stated that the test results suggested "significant limitations of cognitive functioning and performance." He further stated, however, that there was no indication that the Claimant's current functioning was different than his baseline. Dr. Pellegrino noted no history of a direct blow to the head, nor a history of a serious direct head injury, although the Claimant reported that he may have been knocked unconscious when he was injured at work.

Dr. Pellegrino reported that there was no indication that the test results were typical of patients with a closed head injury and the report did not suggest a direct relationship between the test results and the Claimant's injury. Finally, Dr. Pellegrino opined that "the neuropsychological testing results do not indicate, to a reasonable degree of medical certainty, that [the Claimant's] cognitive and performance deficits are the results of his injury on 7/6/2004."

Progress Notes of Dr. R. Gerstle, M.D. (CX 8; EX 25; EX 26)

CX 8, EX 25, and EX 26 contain the progress notes of Dr. Gerstle. The first is from July 11, 2005. The Claimant was referred by Dr. Mingione for an evaluation. He complained that his sleep was being interrupted frequently by pain and that he only slept about five or six hours per night. Dr. Gerstle noted that the Claimant had been married for five months at the time, had been divorced once, and had eight children. He also noted that the Claimant was injured at work when a steel rod hit him in the head and shoulder and knocked him down, sending him to the emergency room.

Upon mental examination, Dr. Gerstle noted that the Claimant was initially alert, but was very sleepy and closed his eyes often. Dr. Gerstle noted that the Claimant reported he was a high school graduate, but did not go to college. He told Dr. Gerstle he had been a longshoreman since 1995. The Claimant reported to Dr. Gerstle that he liked going to church and that before his injury, he liked playing basketball and shooting pool. Dr. Gerstle stated that the Claimant's short-term memory was adequate, as he could describe activities from the prior week, and his attitude was appropriate. The Claimant was able to interpret some proverbs, but not others. Dr. Gerstle's diagnosis was "depression secondary to medical condition, traumatic brain injury."

The second progress note is from August 11, 2005. The Claimant underwent psychological testing to assess his intellectual and memory functioning abilities. Dr. Gerstle noted that the Claimant answered all questions and was generally alert and cooperative during testing, but showed some fatigue. He also noted that the Claimant "appeared to be trying to do his best" and that the test results were valid. Dr. Gerstle reported that the Claimant's "current, full scale, intellectual functioning level, measured by the WAIS-III was in the mentally deficient range. The verbal IQ measuring in the borderline range, while the performance IQ was in the mentally deficient range." Dr. Gerstle's diagnoses were depression secondary to a serious medical condition, cognitive disorder not otherwise specified, traumatic brain injury, and psychosocial stressor moderate to severe. He assessed the Claimant's GAF at 59.

Report of MRI Performed May 31, 2005 (CX 9-3; EX 24)

CX 9-3 and EX 24 contain copies of the June 1, 2005, report by Dr. C. Hecht-Leavitt, M.D. of the Claimant's MRI performed on May 31, 2005. The impression was mild-moderate multifocal cerebral white matter lesions and paranasal sinus disease. The lesions were noted to be most commonly associated with small vessel ischemic change or white matter infarction and were not abnormal for someone of the Claimant's age.

Medical Record from Bon Secours Hampton Roads Laboratory (CX 13)

CX 13 is a copy of the Claimant's January 25, 2006, drug screen, which came back negative for everything but oxycodone.

Prescription for Oxycodone (CX 18)

CX 18 is a photocopy of a prescription written for the Claimant by Dr. Mingione for oxycodone. The prescription is dated November 7, 2006.

Sentara Leigh Hospital Records – July 7, 2004 (EX 10), May 20, 2005 (EX 23)

EX 10 contains copies of the records of Sentara Leigh Hospital from July 7, 2004, the date of the Claimant's work-related injury. The Claimant presented complaining of severe pain and numbness in his right shoulder after being hit with a rod. He was examined and diagnosed with right upper extremity and chest contusions. He was given Motrin and Vicodin for pain and sent home.

EX 23 contains a copy of the Sentara Leigh Hospital Emergency Records from May 20, 2005. The Claimant went to the emergency room complaining of severe, constant pain in his right shoulder with mild swelling. On examination, he had tenderness in the right shoulder and he was able to abduct to ninety degrees, but his range of motion was limited because of pain. He was given pain killers and sent home.

EMG Report – September 7, 2004 (EX 13)

EX 13 contains an EMG report by Dr. Q. Zhu, M.D. The Claimant underwent the EMG on September 7, 2004. On examination, the Claimant had "severe right arm pain with poor effort." The impression was that there was no electrodiagnostic evidence of right-sided cervical radiculopathy and there were incidental findings of right carpal tunnel syndrome and right sensory polyneuropathy, most likely caused by aging.

Dr. Ross – Curriculum Vitae (EX 68); Medical Report (EX 67)

EX 68 is a copy of Dr. Ross's curriculum vitae. Dr. Ross received his M.D. from the University of Connecticut School of Medicine. He is currently a Physician Specialist Advisor for Trigon/Blue Cross/Blue Shield and for Medical Society of Virginia Review Organization/Va Health Quality Center, Director of Community Faculty Affairs at Eastern Virginia Medical School, and the Medical Director of Riverside Rehabilitation Institute. He is currently licensed

in Virginia and is Board Certified in Physical Medicine & Rehabilitation and Electrodiagnostic Medicine, and as an Independent Medical Examiner.

EX 67 contains a medical report from Dr. Ross, dated October 20 2006, after performing an independent medical evaluation and reviewing the surveillance videos and the Claimant's medical records. Dr. Ross noted that the Claimant did not complete a questionnaire before his visit because he is illiterate, but his attorney came with him and wrote the Claimant's responses. The Claimant's attorney remained in the waiting area during the evaluation.

The Claimant described to Dr. Ross his head, neck, and left shoulder problems after a car accident, low back pain, left knee problems, and an injury to his right hand, but he was unable to provide details. Dr. Ross noted that the Claimant believes his high blood pressure stems from his recent work injuries. The Claimant then described his work injury of July 6, 2004. While telling Dr. Ross, the Claimant "became tearful" and stated that he was lucky to be wearing a hard hat, because if he had not, he would have been killed. After he stopped crying, he told Dr. Ross that he briefly lost consciousness, but he did not know for how long. He also told Dr. Ross that the witnesses to the incident "were scared to tell the true story" about how long he was unconscious. The Claimant told Dr. Ross that when he was fully alert again, he noticed pain in his right shoulder, and stated that he had never had problems with his right shoulder before. He reported that he went to an emergency room, but he was not sure which one. He stated that he had a urine drug screen before going to the hospital and that it was negative. He did not know if the hospital referred him to another physician, but his attorney recommended Dr. Wardell.

The Claimant reported that he went to physical therapy, but it did not help. Dr. Wardell performed two shoulder surgeries and he went to physical therapy after each one. He stated that he stopped physical therapy because it was making his symptoms worse. He reported that he also received injections to his shoulder and had imaging studies performed. Dr. Ross noted that the Claimant "became tearful on several occasions when describing his specific injury and how it has ruined his life." He told Dr. Ross that he wanted to return to work because he loved his job and that if his right shoulder problems were resolved, he would be able to go back to work immediately, performing the same job as before his injury.

The Claimant told Dr. Ross that most of his discomfort is in his right shoulder and neck. He stated that the pain was a 7/10 that day, the lowest it had been in the past month was 6/10, the highest it had been in the past month was 10/10, and the average was 8/10. He reported that some days are better than others. Dr. Ross noted that the Claimant had a "high degree of self-perceived disability." The Claimant stated that he occasionally has "unprovoked severe pain in the shoulder that would radiate down the arm" and that the pain causes problems sleeping and causes his blood pressure to rise. He also stated that he feels severely depressed because of his condition, which is affecting his ability to function. He complained of headaches, problems performing overhead activities, and difficulty driving long distances. He also complained of stiff, painful, swollen joints, muscle weakness, nervousness, stress, depression, and anxiety. He stated that he cannot lift anything heavier than a can of soda out of the refrigerator.

The Claimant informed Dr. Ross that he has asthma, hypertension, arthritis, psychiatric problems, and right shoulder problems. He sometimes wore a sling for his right shoulder, but

did not wear it all the time because it hurt his left shoulder and neck. He stated that he took oxycodone and estimated he took four or five per day, but some days he did not take any. He also stated that he took medication for blood pressure and sleep, and took Tylenol and Aleve.

The Claimant stated that his typical day consisted of watching television. He reported that he currently lived alone and his children helped him take care of the apartment. He stated that he did not perform any vocational activities, but went to the YMCA to use the hot tub. He usually went out daily and drove short distances, but he would not always take oxycodone if he was going out because he was afraid it made him sleepy and unsafe. He stated that he went to church about three days per week. He reported that his car had an automatic transmission, but he once drove a relative's car, which had a manual transmission. He felt that this is why his worker's compensation was cut off.

Dr. Ross noted that Dr. Wardell had placed the Claimant on total disability and that he was receiving Social Security Disability. He reported that the Claimant had a first or second grade education and he could not get a good answer as to how he stopped going to school. The Claimant related the story about being accused of stealing a quarter from another student, which caused him so much humiliation that he did not return to school. Dr. Ross stated that the Claimant is illiterate and cannot write.

On examination, the Claimant was cooperative, but became emotional and cried on occasion. He told Dr. Ross that he had a good range of motion in his neck, except when his right shoulder was in pain. He demonstrated a functional range of motion for Dr. Ross. Dr. Ross measured the Claimant's forearm circumferences and they were two centimeters different, with the right being greater. He noted that the Claimant's muscle definition was "quite good in both upper extremities." The Claimant had normal muscle strength in all four extremities, except at the right shoulder, where pain inhibition limited the test in all four planes. When his right arm was at his side, he could abduct "fairly forcefully." Dr. Ross performed a Jamar dynamometer grip strength test on both hands and he stated that the results from the Claimant's right hand were inconsistent.

Dr. Ross asked the Claimant to lean to the right and left while standing up, and the Claimant complained that it hurt his right shoulder. The Claimant's muscle stretch reflexes were symmetrical, and his sensation to pin-prick was symmetrical in all four extremities. Dr. Ross reported that the Claimant was "extremely tender to palpation of the entire right shoulder girdle," but there as no tenderness on the left. The Claimant did not have spasm. He gave a good effort in pulling his head against fixed resistance and his strength was normal. He complained of right shoulder pain when Dr. Ross braced himself on the Claimant's right shoulder.

Dr. Ross measured the Claimant's active range of motion with a goniometer. The Claimant's range of motion on the right increased when he allowed Dr. Ross to assist him.[19] Dr. Ross did

[19] On the right, the Claimant's abduction was 60 degrees (80 degrees with passive assistance), adduction was 10 degrees, forward flexion was 50 degrees (80 degrees with active assistance), backward extension was 60 degrees, internal rotation was 10 degrees (90 degrees with active assistance), and external rotation was 60 degrees (90 degrees with active assistance). If his shoulder was not abducted far, his external rotation was 90 degrees with no assistance.

not detect any spasm during the examination. His initial impression was that "[t]here was no apparent injury from today's examination."

Dr. Ross reviewed the surveillance tapes from August of 2005 and January-February of 2006. He noted that the Claimant kept his arm down in a non-useful position in public, but did not hold his arm in that manner in non-public settings. He stated that "[w]ithout having any knowledge of which shoulder (if any) was problematic, I would not have been able to determine which shoulder was the affected one by watching the majority of the surveillance video." He also stated that the Claimant's "seemingly unlimited use of the right upper extremity on the videotape is in contrast to what he told me he could do and compared to what I observed during my evaluation of him." He then reviewed the Claimant's medical records.

Dr. Ross also reviewed job analyses for a hustler driver, general longshoreman/container vessels, slinger-spotter/container ship, winchman, and light duty painter/power washer. He opined that all the jobs were within the Claimant's abilities, with the caveat that for the light duty painter/power washer job, there be someone to assist him in lifting the fifty-six pounds required.

After review of all the materials and evaluating the Claimant, Dr. Ross opined that "it is my medical opinion that his subjective complaints are not credible." Dr. Ross stated that the Claimant has some discomfort and may believe he has the limitations he claims, "but the degree of functional impairment he claims is greater than what is observed." With respect to an impairment rating, Dr. Ross stated that "an Impairment Rating based on range of motion [is] inappropriate" because it should only be given "if [the] measurements are consistent and believed to be accurate." After reviewing the surveillance, Dr. Ross did not believe this to be so. Thus, he assessed the Claimant's impairment rating only based on his acromioclaviclar joint resection. Using the AMA Guidelines, Dr. Ross assessed a 10% upper extremity impairment, which equals a 6% whole person impairment.

Medical Records of the Claimant's Prior Injuries (EX 46-51, 63)

EX 46 contains a report from March 29, 1994, when the Claimant suffered a muscle strain in his low back. EX 47 contains a copy of medical records from the Claimant's September 21, 1997, motor vehicle accident. The Claimant was treated by Dr. N. Karp, M.D. on September 24, 1997. He reported being hit on the right foot, complained of dizziness and low back problems, and rated his pain a six or seven out of ten. He stated that he had gone to the emergency room the day of the accident, but it was too crowded, so he saw his doctor a few days later. His x-rays were negative. He reported that he was not working because of the accident and Dr. Karp kept him out of work pending a follow-up visit on October 3, 1997.

EX 48 contains a medical report from Dr. Karp, dated November 1, 1997, regarding the Claimant's accident. The Claimant's van was hit on the passenger side, front corner panel and on the passenger side, rear corner panel. The collision caused his body to snap and he was thrown to the left and forward. His head hit the door window and he was almost knocked unconscious. His left knee and left shoulder hit the door and his abdomen and chest hit the steering wheel. Dr. Karp examined the Claimant on September 24, 1997. The Claimant complained of bad lower back pain, left knee pain, bad headaches, neck pain, and a sore

abdomen. He reported two or three bifrontal headaches per day which lasted an hour or less and which caused blurred vision, photophobia, slight tinnitus, vertigo, and nausea, but not vomiting. He denied prior history of headaches, but reported a prior motor vehicle accident in which he sustained a concussion. He also denied prior history of neck, back, and left knee injuries. Dr. Karp diagnosed acute cervical and lumbar sprain, post-traumatic headaches, left shoulder contusion, injury to the AC joint and glenoid labrum, and left knee contusion. He prescribed a muscle relaxer, an anti-inflammatory agent, and an analgesic.

The Claimant saw Dr. Karp three more times for his injury and underwent x-rays and an MRI. The MRI showed a small central disc protrusion at C2-3, a mild diffuse posterior disc protrusion at C3-4, and a small central disc protrusion at C4-5. On October 3, 1997, the Claimant also told Dr. Karp he had had hand surgery about twenty years prior and had a "good, but not complete, recovery." On examination, his grip strength was weaker in the right hand than the left.

EX 49 contains copies of medical records from Dr. A. Dickson, M.D. The Claimant saw Dr. Dickson on September 15, 1998, complaining that his right hand was numb and that it ached. Dr. Dickson made note of an old injury to the Claimant's right hand. On April 1, 1999, the Claimant saw Dr. Dickson complaining of back and leg pain, stemming from a March 29, 1999, motor vehicle accident. He also complained again about problems with his hand. He returned for follow-up on April 5, 1999.

EX 50 contains a copy of medical records from the Sentara Norfolk General Hospital from April 28, 2002. The Claimant went to the hospital emergency room on April 28, 2002, after being hit in the face and mouth with a steel rod. He was seen by Dr. L. Givonetti, M.D. An x-ray revealed multiple missing teeth, but no fractures or acute abnormalities. Dr. Givonetti diagnosed him with a mandible contusion. He was given Vicodin and was instructed to take Motrin and Tylenol for pain. He was also instructed to see his dentist.

EX 51 contains a copy of the Claimant's medical history from April 25, 2005. The Claimant admitted to having the following: albumin/sugar/pus/blood in urine; arthritis; asthma; back/arm/leg problems; depression or anxiety; difficulty concentrating; dizziness; extreme tiredness/weakness; fainting spells; frequent or severe headaches; hallucinations; high blood pressure; memory problems; night sweats; shortness of breath; and trouble with nose, sinuses, mouth, throat.

EX 63 contains medical records from 2000 and 2001. The Claimant saw Dr. Wardell on May 1, 2000, for an evaluation of his low back and legs, which he injured in a motor vehicle accident on March 25, 2000. The Claimant had gone to Patient First for an examination and x-rays and was given a muscle relaxer and a pain reliever. He was also examined by Dr. Holden, who ordered an MRI which revealed a degenerative disc and disc bulging and protrusion at L5-S1 and prescribed Prednisone. Dr. Wardell examined the Claimant and reviewed the MRI and x-rays. He diagnosed the Claimant with L5-S1 disc herniation and contusion of the right hand. The Claimant was instructed to begin physical therapy and he was scheduled for an epidural steroid injection.

The Claimant returned on May 12, 2000, complaining that his right hand and back were painful and that the back pain radiated into his legs. Dr. Wardell instructed the Claimant to continue physical therapy and return in two-and-a-half weeks. On May 23, 2000, the Claimant returned still complaining about his right hand and back. Dr. Wardell sent him for EMGs of the right upper and lower extremities. The Claimant returned twice in June of 2000 for follow-ups, reporting that he had some improvement with physical therapy. He was released to work beginning July 24, 2000.

The Claimant saw Dr. Wardell three times in August of 2000, complaining of increased pain in his low back, right leg, and left leg. On October 20, 2000, the Claimant saw Dr. Kerner, who ordered an FCE and recommended that the Claimant return to work full-time. He did not return to see Dr. Wardell until February 1, 2001, when he complained of intermittent low back pain. Dr. Wardell noted no clinical change and instructed him to continue working.

In March and June of 2001, the Claimant went to Dr. Wardell complaining of right hand pain. On June 12, Dr. Wardell tested his grip strength, which was fifty pounds on the right and ninety pounds on the left. Dr. Wardell noted at that visit that the Claimant was ambidextrous. He diagnosed the Claimant with possible tendonitis and possible neuropathy and referred him to Dr. Lannik.

The last medical record is dated July 6, 2001, and states that the Claimant was referred by Dr. Wardell for evaluation of his right hand, but the name of the doctor who performed the evaluation is not given. However, since Dr. Wardell referred the Claimant to Dr. Lannik, it is presumably his evaluation.[20] The evaluator could not identify a "satisfactory objective abnormality . . . with regards to nerve, tendon, muscle, or skeletal function. His prognosis is poor due to the postural inability to grasp properly."

Norfolk Physical Therapy Center – FCE Reports:

FCE Report – January 18, 2005 (EX 15)

EX 15 contains the report of an FCE performed on January 18, 2005, by M. Loumeau, a physical therapist at Norfolk Physical Therapy Center. Mr. Loumeau reported that the Claimant's test findings and clinical observations suggested he was giving variable levels of physical effort and that he could do more at times than what he demonstrated. He stated that "[o]verall test findings, in combination with clinical observations, suggest considerable question be drawn as to the reliability/accuracy of [the Claimant's] subjective reports of pain/limitation." He also stated that "[s]ignificantly more weight should be placed objective findings versus subjective reports."

Mr. Loumeau's testing showed that some of the test results were inconsistent. Mr. Loumeau noted that, although the Claimant reported functional pain scores exceeding five during several tests, he was able to complete them without a break. The Claimant also tested positive for three of seven Waddell non-organic signs. His perceived strength on Sort tests was, however, consistent with his demonstrated ability. He could perform overhead work with his left arm, but

[20] Dr. Wardell testified at his deposition that the physician who wrote the note was Dr. Lannik, whom he referred the Claimant to. (CX 1 at 38.)

not with his right arm with distraction-based testing, primarily because of his right shoulder range of motion and strength deficits.

The Claimant's demonstrated physical strength was as follows: lift twenty-five pounds from floor to waist occasionally; lift twenty pounds waist to shoulder occasionally; lift twenty pounds overhead with left arm occasionally; carry twenty-five pounds fifty feet occasionally; push with thirty-eight pounds of force occasionally; and pull with forty pounds of force occasionally. His demonstrated mobility abilities were walking, static standing, dynamic standing, and sitting on a frequent basis. His demonstrated agility was as follows: negotiate twenty stairs and thirty ladder rungs occasionally; negotiate a twenty-three inch high step with either leg; walk on four inch wide plank for twelve feet with eyes open; maintain single leg balance for thirty seconds on each leg; bending, stooping, crouching, and squatting frequently; crawling and twisting occasionally; left arm above-shoulder work occasionally; low-level work frequently; and prolonged neck flexion occasionally. He also demonstrated the ability to grasp both lightly and firmly, pinch, and fine finger frequently, the ability to reach forward frequently with his left arm and occasionally with his right arm, and the ability to write occasionally. No limitations were noted with respect to his vision and hearing.

Overall, Mr. Loumeau determined that the Claimant demonstrated the ability to perform light to medium duty work. He stated that the Claimant met the physical requirements to work as a Groundsman, Slinger (Container Ship Spotter), Top Loader/Reach Stacker Operator, and Hustler Driver.

Mr. S. Schall – FCE Report (EX 30); Surveillance Report (EX 31); Report (EX 53)

EX 30 contains the report of an FCE performed by S. Schall, a physical therapist at Norfolk Physical Therapy Center, on September 8, 2005. Mr. Schall noted that the Claimant's test findings and clinical observations suggested that he was giving sub-maximal effort and that he could do more than he demonstrated. He stated that "[o]verall test findings, in combination with clinical observations, suggest [the Claimant's] subjective reports of pain and associated limitation to be unreliable and inaccurate."

The Claimant arrived for the evaluation holding his right arm limply at his side and he did not use it until he needed to use his inhaler, which he did without any apparent difficulty. The Claimant's cervical range of motion was "two finger widths from chin to chest" in flexion, forty-five degrees in extension, right rotation was thirty degrees, and left rotation was thirty-five degrees. He complained of increased pain even with mild overpressure. On examination of the Claimant's left arm, flexion was 150 degrees, abduction was 100 degrees, external rotation was fifty degrees, internal rotation was to the T12 level, and elbow pronation was limited to thirty-five degrees. He complained that passive ranging of his left shoulder aggravated his right shoulder. On examination of his right shoulder, the range of motion was limited to fifty-five degrees flexion and thirty-five degrees abduction, and external rotation was thirty degrees. During ranging of the shoulder, a "small audible pop" was noted and the Claimant immediately complained of severe pain, which according to his wife was not unusual. He stated that his pain level had risen from 7/10 to 10/10. Testing was terminated after the increase in pain level and an elevated blood pressure reading. His heart rate remained near sixty during the evaluation.

The Claimant returned the following day with his right arm in a sling to perform functional testing on his left arm. He reported that he had gone to the emergency room, but it did not help. He reported pain of 8/10 initially. He performed some lifts with his left arm of seven pounds at waist level and five pounds at shoulder level and down to the twelve inch level, but would not lift from lower because of pain in his right shoulder. A Valpar work sample was attempted for fourteen minutes, but was not completed because of the Claimant's complaints of increased pain. The Claimant worked very slowly and "well below industrial standards for upper extremity usage." Mr. Schall stated:

> I am unable to provide any accurate data on the functional abilities of the [Claimant]. As he reported difficulty with even prolonged standing, sitting, or walking due to severe arm pain and the need to take medication and lie down, he would not qualify for any position as a longshoreman based on these complaints. After review of his medical records and a clinical evaluation, I can find no physical pathology that would account for the [Claimant's] complaints. There is substantial evidence to indicate a more behaviorally based origin for his current condition.

EX 31 contains a report by Mr. Schall after his review of the surveillance video on September 22, 2005. Mr. Schall noted that the video showed many time periods where the Claimant used his harm in a "spontaneous fashion, with no sign of dysfunction," while only two showed him holding his arm at his side as he did during his FCE. For example, he noted that the Claimant used his right arm in a normal fashion and without any difficulty when opening and closing car doors, scratching his head, reaching into a car trunk, lifting and carrying objects, and steering with his right hand when backing out of a parking space. He stated that these actions were "in marked contrast to the FCE where he presented with the right arm at his side and virtually no active usage of it" and complained of severe pain with limited passive motion.

Mr. Schall also noted that the Claimant did hold his right arm at his side twice on the video as he did when at his FCE, but one of those times, the Claimant subsequently reached out fully with his right arm to close the car door. He stated that this was consistent with the Claimant's actions at the FCE where he held his right arm at his side, but when he was not paying attention, he displayed normal motion without pain. His opinion was that when the surveillance video and FCE are taken together, they "suggest that the [Claimant] is making an effort to hold his arm in a certain position, but, when distracted or not paying attention, is capable of using his right arm without difficulty for light activities."

EX 53 contains a copy of Mr. Schall's December 23, 2005, report. Mr. Schall stated that he went to the Employer's office to meet with the Claimant to determine his ability to operate a hustler. The Claimant presented with his right arm held at his side. He climbed the steps to the hustler and got in using his left arm. He mostly used his left arm to put on his seat belt, but he had more trouble with that. He operated the controls on the right side, the automatic gear shift, the fifth wheel control, and the brakes with his right and left hands together or with his left hand only. He was unable to operate the controls with his right hand only. Mr. Schall observed the Claimant's right arm shaking "considerably," but he did not know why. As they drove around

the parking lot, they hit a few potholes and the Claimant "flinched and cried out in pain." However, when he was describing the problems he was having and they went over potholes, he did not react. As he was backing up to the container, the Claimant cried out again when the fifth wheel made contact with the container. He got out of the hustler and attached the hoses using only his left arm. He told Mr. Schall that he did not feel comfortable driving with the container attached to the hustler, because he did not think he could control the steering wheel if he had to pull hard, so they detached the container and drove back to the parking spot. The Claimant got out of the hustler without using his right hand.

The Claimant gave Mr. Schall a note from Dr. Wardell, dated December 2, 2005, which stated that the Claimant was completely disabled from work because of his oxycodone use. He gave Mr. Schall another note from Dr. Wardell's physician's assistant, dated December 6, 2005. That note stated that the Claimant could return to work with his left arm only, but it encouraged him to use his right arm as much as possible when not at work to decrease pain and maintain range of motion. Mr. Schall opined that "some pain behaviors were present, but the [Claimant] was unable to demonstrate the capacities necessary for safe operation and usage of the Hustler in the job of Hustler driver."

Surveillance:

Surveillance Videos – August 8-9, 2005 (EX 35), January 31, 2006 – February 3, 2006 (EX 61)

EX 35 is a surveillance video of the Claimant taken August 8 and 9, 2005. The Claimant has acknowledged that he is the man on the video. (EX 38; TR at 77-81.) Relevant portions of the video are described herein. On August 8, 2005, at 12:01 p.m., the Claimant picked up his cell phone in his right hand and then opened his gas cap with his right hand. At 12:33 p.m., the Claimant steered his van with his right hand as he held his cell phone with his left. At 12:47 p.m., the Claimant closed his car door with his right arm.

The next day, the Claimant opened and closed his car door with his right arm at 9:52 a.m. At 9:54 a.m. and 1:32 p.m., the Claimant closed his car door with his right arm. At 1:48 p.m., the Claimant was shown carrying a coat and throwing it into a trunk with his right arm. He was again shown opening and closing his car door with his right arm at 2:27 p.m. At 2:33 p.m., he closed the trunk of his car by reaching above his head with his right arm. At 3:52 p.m., he was shown carrying a soda in his right hand.

EX 61 is a surveillance video of the Claimant taken January 31, 2006, February 1, 2006, and February 3, 2006. The Claimant has acknowledged that he is the man on the video. (TR at 81-84.) Relevant portions of the video are described herein. On January 31, 2006, at 4:54 p.m., the Claimant was seen raising his right arm above his head to put on his jacket while his arm was in a sling. On February 3, 2006, the Claimant was seen on his balcony talking on his cell phone for more than fifteen minutes, from 11:29 a.m. to 11:45 a.m. The Claimant was not wearing his sling and was constantly gesturing with his right hand. He also raised his right hand to scratch his head at 11:29:23 a.m. and 11:44:57 a.m. About twelve minutes later, at 11:57 a.m., he was seen leaving his home wearing a sling on his right arm. At 12:02:45 p.m., he was seen talking and gesturing with his right arm while it was still in the sling. A short while later, at 12:40 p.m.

he was seen using his right hand to hold his cell phone to his ear while his arm was still in the sling. Finally, at 3:21:50 p.m., the Claimant opened a van door with his right arm.

Claimant's Work and Earnings Information:

Claimant's Check-In Records (CX 12)

CX 12 contains copies of the Claimant's ILA check-in records from 2006. He checked in on January 19, 20, and 24-27, February 7-9, 14, 16-18, 20, and 24, and March 1-7, 11, 12, 14-16, 18, 22, 24, and 27.

Claimant's Work History (CX 14; EX 62)

CX 14 is a printout of the Claimant's work history between December 30, 2003, and September 30, 2005. Of the 121 days the Claimant worked during that period, he worked as a general longshoreman for fifty days, a lasher for forty-nine days, a driver for sixteen days, a slinger for five days, and a K7 for one day. EX 62 contains a printout with most of the same work history, except that it begins October 2, 2003, and ends July 29, 2004. Between October 2, 2003, and December 30, 2003, the Claimant worked forty-nine days, the majority of which were as a general longshoreman.

Earnings Information for the Period of July 6, 2003 – July 6, 2004 (EX 6; EX 32)

EX 6 and EX 32 contain the Claimant's earnings information for the one year prior to his work injury. The Claimant earned $22,931.20 from the Employer, $10,395.30 from Cooper/T.Smith, $10,346.68 from Universal, and $20,272.86 from P&O Ports. In 2003, he also earned $6,703.44 from the HRSA-ILA Vacation and Holiday Fund and $8,107.14 from the HRSA-ILA Container Royalty Fund. His earnings totaled $78,756.62, a total which was then used to calculate his average weekly wage of $1,514.55.

Work Record from February 2005 (EX 7)

EX 7 contains the Claimant's work record from February 2005, which showed three days of work. On February 18, the Claimant worked four straight-time hours, 8.5 overtime hours, and one double-time hour as a general longshoreman. On February 19, he worked 9.5 overtime hours as a driver. Finally, on February 23, he worked eight straight-time hours and two overtime hours as a general longshoreman.

Other Evidence:

Deposition of the Claimant's Wife – December 15, 2005 (CX 6)

The Claimant's wife was deposed on December 15, 2005. She testified that she had been married to the Claimant for nine months, but had known him for over 25 years. She stated that they were married after the Claimant's work injury. They did not live together before they were

married, so she could not observe him then. She reported that she did not have any pictures or video of the wedding.

The Claimant's wife testified that she returned to this area in July of 2004, and when she met with the Claimant, he was wearing a sling. She stated that while they were dating, they did not travel, but after they married, they traveled to Charlotte and Greensboro, North Carolina for two church events in September and October of 2005, respectively. She reported that each trip only lasted a weekend, during which they stayed in a hotel and went to church. She stated that they took the Claimant's BMW and she drove about 75% of each trip, while the Claimant drove the remaining 25% of each trip. She stated that the Claimant drove with his left hand and occasionally used the fingers of his right hand on the steering wheel.

The Claimant's wife testified that she had never seen the Claimant reach up and close the trunk of his car with his right hand. She stated that she had seen the Claimant carry clothes and a jacket with his right arm. She has seen the Claimant use a broom to sweep, but she never paid attention to whether he used both hands. She stated that he usually uses his left hand to hold his cell phone and she had never seen him use his right hand. She further stated that she would be surprised if the Claimant could hold his cell phone in his right hand while talking, but later stated she would not be surprised because the Claimant's ability to hold something in his right hand depended on its weight and she knew a cell phone did not weigh much. She repeated that she had never seen the Claimant use his right hand to hold his cell phone up to his ear.

The Claimant's wife stated that she had talked about the Claimant with Isabella Harwell. She reported that Ms. Harwell told her the Claimant's doctor thought he had dementia and that he had "one foot out of a nursing home." She stated that she told Ms. Harwell at one time that the Claimant was expecting a large settlement and that he wanted to dump her before he got the money. She told Ms. Harwell this when they were discussing the Claimant's strange behavior. She stated that the only reason she thought he was expecting a large settlement because he was injured and had an attorney. She also stated that he had not told her he was expecting a large settlement and there was nothing in his behavior that made her think he thought he was getting a lot of money. She did not know why she thought the Claimant wanted to dump her, other than because he was acting strangely.

The Claimant's wife testified that after Ms. Harwell told her the Claimant had dementia, she looked it up on the Internet. She stated that the doctor told the Claimant not to drive because he thought the Claimant might not remember how to get home. She testified that she had noticed some strange behavior in the Claimant and stated that his attitude and demeanor changed, but she did not know whether it was due to medication. She stated that sometimes the way he acted and talked changed, like he would stutter at times and his behavior would become more exaggerated.

Miscellaneous Letters and Documents (CX 15; EX 1, 1A, 2, 3, 4, 5, 8, 9)

CX 15 contains various letters and forms. The first document is U.S. Department of Labor form LS-1, the Request for Examination and/or Treatment. The second is U.S. Department of Labor form LS-206, the Payment of Compensation without Award. The LS-206 indicates that the

Claimant's average weekly wage was $1,514.55, that compensation would be paid from July 8, 2004, and that medical care has been provided by a physician chosen by the Claimant.

CX 15-3 and EX 1A are copies of U.S. Department of Labor form LS-207 dated October 31, 2005. The Employer controverted the causal relationship of the Claimant's head and neck injuries to the work-related accident and the extent of the Claimant's disability after October 19, 2005, based on Dr. Mansheim's report.

CX 15-4 and EX 1 contain copies of U.S. Department of Labor form LS-208 dated October 31, 2005. The Claimant was paid based on an average weekly wage of $1,514.55, which produces a compensation rate of $1,009.70. He received temporary total disability benefits from July 7, 2004, to February 14, 2005, inclusive, and from March 1, 2005, to October 19, 2005, inclusive. He also received temporary partial disability benefits from February 15, 2005, to February 28, 2005, inclusive. The Employer terminated benefits on October 19, 2005, because the Claimant was able to return to work. The Claimant received a total of $66,684.33 in compensation, although the Employer alleges a $721.23 overpayment of temporary total disability benefits.

CX 15-5.1 and 5.2 are the Memorandum of Informal Conference and have been admitted for the sole issue of attorney fees. CX 15-6 is a letter from the Employer's counsel which states the issues for adjudication. CX 15-7 is a second LS-207, dated May 17, 2006. The Employer controverted the Claimant's right to future medical treatment as unnecessary because the Claimant allegedly misrepresented his condition to doctors.

EX 2 is a copy of the Claimant's LS-203 dated June 8, 2004. The Claimant reported that a lashing rod struck him on the right shoulder just after midnight on July 7, 2004, and he received medical treatment at Sentara Leigh Memorial Hospital. The only injury listed is the injury to his right shoulder. He listed his job as lasher for the Employer.

EX 3 is a copy of the LS-202 dated July 12, 2004. The Claimant was injured when the ship's cleaning crew knocked down a 3-high lashing rod while he was lashing. He was noted to have sustained a right arm, shoulder, and chest contusion. Medical attention was authorized by the Employer and the Claimant selected the first treating physician, Dr. Wardell.

EX 4 is a copy of the Virginia Workers' Compensation claim form dated July 8, 2004. The Claimant reported his right shoulder as his only injury.

EX 5 is a copy of the OSHA Form 301 Injury Report dated July 7, 2004. Superintendent J. Ackerman completed the form. The Claimant was working as a lasher when a 3-high rod was knocked off the ship, injuring his right arm, right shoulder, and chest. He began work at 7:00 pm on July 6 and the injury occurred at 12:50 am on July 7. He was treated by Dr. Webb at Nowcare and was noted to have an appointment with Dr. Wardell on July 12, 2004.

EX 8 contains a letter from Ms. G. Escueta, an OWCP rehabilitation specialist, dated February 23, 2005. The letter indicates that the Claimant was contacted twice regarding the OWCP's optional vocational rehabilitation program. He did not respond to the first letter, but responded

to the second, stating that "he wanted to make every effort to return to longshore work and was not interested in services at this time."

EX 9 contains a letter from the Employer dated May 5, 2005, regarding the Claimant's benefits. The Employer informed the OWCP that the Claimant had worked three days between February 18, 2005, and February 23, 2005, and that it had paid temporary partial disability benefits based on his average weekly wage minus his earnings for that period. It also reported reinstating the Claimant's temporary total disability benefits the week of February 22, 2005, and continuing because of the Claimant's second surgery, which it had authorized.

Claimant's Answers to Interrogatories and Request for Admissions (CX 17; EX 34, 38)

CX 17 contains copies of the Claimant's answers, dated April 25, 2006, and amended answers, dated October 20, 2006, to the Employer's interrogatories. The Claimant reported sustaining six injuries between 1998 and 2002. Five of the injuries were sustained at work: April 12, 1998 (right hand); March 29, 1999 (back); March 25, 2000 (low back, right hand, both legs); October 11, 2001 (left ring finger); and April 28, 2002 (mouth and teeth). He also sustained a low back injury in an automobile accident on January 4, 2002. The Claimant also reported that he went to school through second grade and he cannot read or write.

EX 34 contains a copy of the Claimant's interrogatory answers dated November 7, 2005. EX 38 contains the Claimant's answers to the Employer's Request for Admissions dated November 21, 2005. The Claimant admitted that he was the person shown on the surveillance film dated August 8 and 9, 2005. Portions of this video are described in EX 35.

Job Analyses (CX 19; EX 17, 41, 69-71)

CX 19 is a copy of a regular duty slinger job analysis for the Claimant dated August 20, 1999. The duties consisted of directing hustler drivers and locking and removing twist locks. The description indicated that the automatic twist locks weighed eight pounds. The job description was disapproved on June 5, 2000, but the doctor's signature cannot be read.

EX 17 contains copies of eleven job analyses, eight of which Dr. Wardell approved on February 14, 2005. The approved jobs were: top loader/reach stacker operator; slinger, container ship spotter; hustler diver; groundsman to assist top loader; forklift operator; dock foreman; ship foreman; and line handler. None of these positions required reaching above shoulder height or working with arms extended at shoulder level. The disapproved jobs were: lasher; general longshoreman/container vessels; and gangwayman. The lasher and gangwayman jobs required reaching above shoulder height, while the general longshoreman job required some work with arms extended at shoulder level.

EX 41 contains copies of job approvals from Dr. Cohn dated November 30, 2005. Dr. Cohn approved the following jobs for the Claimant: groundsman/top loader; winchman; slinger/container ship spotter; and general longshoreman/container vessels. He disapproved the following jobs: gearman; lasher; line handler; and gangwayman. It appears that he disapproved

line handler because of the fifty to sixty pound weight lifting requirement and gangwayman because of reaching above shoulder height.

EX 69 contains corrected job analyses for three jobs: general longshoreman/container vessels; slinger-spotter, container ship; and hustler driver. The weight of the twist locks was listed as eighteen pounds. Dr. Ross approved all three jobs as corrected on October 27, 2006.

EX 70 contains corrected job analyses for two jobs: general longshoreman/container vessels and slinger-spotter, container ship. The weight of the twist locks was listed as eighteen pounds. Dr. Cohn approved both jobs as corrected on October 30, 2006.

EX 71 contains the corrected job analysis for the light duty painter/power washer job. The job duties were power washing with a pressure hose, painting equipment with a paint brush or hand roller, and some grounds/building maintenance. The maximum lifting requirement was twenty pounds, rarely, and assistance was usually available. The description shows that there is intermittent reaching above shoulder height and working with arms extended at shoulder level.

Claimant's Deposition Transcript – November 10, 2005 (EX 39)

EX 39 is a copy of the transcript from the Claimant's November 10, 2005, deposition. The Claimant testified that he did not read the interrogatory answers for his state Workers' Compensation case before he signed them on November 4, 2005, because he does not read. He could not remember at first whether someone read the answers to him, but he did remember after being shown the affidavit he signed. He testified that he is "not close" to being able to read. He testified that he only got to second or third grade in school and that he went to Diggs Park, Bowling Park, and Ruffner Middle in Norfolk.

The Claimant stated that he has seen both Dr. Gerstle and Dr. Mingione, but neither has given him a written test. He reported that all the information he gave them was verbal. He testified that he did not tell Dr. Gerstle that he graduated from high school, even though Dr. Gerstle's July 11, 2005, report shows that. He stated that he told Dr. Gerstle that he went to second or third grade.

The Claimant stated that he was injured on July 7, 2004, when "a mate came through and knocked the three-high lashing rod down and it hit me." He did not know how far the rod fell. He stated that the rod hit his hard hat first and then his right shoulder. He reported that the rod did not hit any other part of his body, but he did not know what happened to it next, because "it kind of put me out for a few seconds." He testified that he did lose consciousness, but was not sure exactly how long he was out. He reported that his whole body felt numb after he woke up and that he had a lot of pain. He also reported being dizzy and having a headache the day of the accident. Prior to the July 7, 2004, injury, the Claimant testified, he had not had any prior head injuries, problems with headaches, or injuries or problems with his right shoulder or right arm.

The Claimant verified that his signature was on VWC form number 5 dated July 8, 2004, which was his claim for Virginia Workers' Compensation benefits. He remembered signing the form, but he did not fill it out and he did not know who did. He did not know where he signed the

form, but his counsel stated that an employee in his office filled out the form while the Claimant present. The Claimant reported that he told the employee the information, she filled out the form, and he signed it. He stated that he did not know his head was injured at that time – he thought everything was coming from his shoulder – so he did not tell her his head was injured. He could not remember if he told her the lashing rod hit his head.

The Claimant stated that he knew John Ackerman and thought he was a foreman or superintendent. He did not remember if he had talked to Mr. Ackerman when he was injured because he was in so much pain.

The Claimant recalled that he went to the hospital the day of his injury. He stated that he told the hospital that he had been hit by a three-high lashing rod. He could not remember if he told them where the rod hit him because it has been so long and he was in a lot of pain.

The Claimant testified that someone referred him to Dr. Wardell, but he could not remember who provided the referral. Three weeks after his injury, the Claimant reported, Dr. Wardell sent him back to work. He stated that he had so many restrictions that no one wanted to give him a job, but a friend gave him a job as a forklift driver. He knew that the person's name was Jerry and that he was the header of a gang, but he did not know his last name. He stated that he worked at Lambert's Point, but he did not know for which employer he worked. He reported that the day he returned to work, he started to move the forklift lever, but was in a lot of pain and Jerry told him "[y]ou can't fake it. . . . Get off." He tried to work the forklift with his left hand because his right arm hurt so much, but he was getting behind and Jerry told him it was not going to work. He guessed that he operated the forklift for about thirty minutes, but sat in it for about an hour. He stated that he stayed on the job the rest of the day, but did not do anything other than watch the freight and tell the men where to put it. He reported that while he was watching the freight, he took the crane hooks out of the pallets with his left hand, but he did not directly handle pallets or the chains or wires attached to the pallets. After that one day on the job, the Claimant testified, he thought he went back to either the emergency room or Dr. Wardell's office.

The Claimant confirmed that Dr. Wardell performed surgery on his shoulder in September of 2004. He testified that the surgery and subsequent physical therapy did not make his shoulder any better than it was before the surgery. He recalled then being sent for an FCE in January of 2005. He testified that he gave his full effort during the evaluation and that the pain he complained of was real. He could not remember if Dr. Wardell sent him back to work with restrictions after the FCE. The Claimant then confirmed that Dr. Wardell performed a second surgery on his shoulder in May of 2005. He testified that it did not improve him at all. He stated that he had the second surgery because the pain "was shooting through my shoulder and . . . going up my neck and my head, centered on the right side of my face."

The Claimant could not remember when he started seeing Dr. Mingione. His counsel reported that Ms. Harwell scheduled the first appointment for May 9, 2005, which is the same date on Dr. Mingione's first report. The Claimant did not know for sure who referred him to Dr. Mingione, but he thought it was someone in Dr. Wardell's office. He stated that he told Dr. Mingione that when his arm is in a lot of pain, he holds it because it is more comfortable, but he did not tell Dr.

Mingione that he had to keep his right arm at his side. He testified that he told Dr. Mingione the truth when he said he could not use his right arm at all because of the pain. He reported that there was never a time he presented to Dr. Mingione where he was disoriented.

The Claimant reported that Dr. Mingione treated him with pain medication and told him not to drive at one point, which he thought it was because of the pain medication. According to the Claimant, Dr. Mingione did not explain to him why he did not want him to drive and he did not think Dr. Mingione ever discussed the possibility of cognitive problems with him, but may have with his wife. He stated that Dr. Mingione explained to Ms. Harwell why he could not drive and she told him that "I had something and I was on my way to the nursing home." However, he testified, he did drive after Dr. Mingione told him not to, because he is hardheaded, but he did not get in any accidents or have any problems because he drove with his left hand. He reported that he drives a BMW 745 and a Chevrolet van, both of which have automatic transmissions. While he may have tried to use his right arm to drive or steer, he stated that he knows he cannot. He confirmed that he operates the steering wheel "[t]otally with my left" hand. He stated that even though he can lift his elbow to hold his cell phone up to his right ear, he just cannot turn the wheel of a vehicle with his right arm. The Claimant could not recall for sure when he last saw Dr. Mingione, but thought it was the previous month. He stated that Dr. Mingione does not give him treatment other than about four or five different medications, one of which helps him sleep.

The Claimant testified that he has worked as a slinger in the past, but he could not be a slinger now because he would have to move his arm a lot. He explained that slingers work under cranes spotting trucks and that they use both hands, but most of the time they use their right hand to spot. He stated that when he worked as a slinger, he had to lift ten to fifteen pound pins or twist locks out of the corners of the containers. A groundsman, he explained, does the same things as a slinger, placing and removing pins in the corners of containers, and must also make sure the chassis is unlocked. He reported that the groundsman also has to pull chains, but it depends on the type of freight coming off and going on the ship.

The Claimant testified that he has also worked as a hustler driver in the past, the last time being sometime in 2004. Hustler drivers "go get the freight, bring it back, take the freight from the ship, put it where it's supposed to be, get back to the ship." He confirmed that a hustler is basically an 18-wheeler tractor-trailer and it has an automatic transmission. He testified that he could not do the job now because there is too much arm movement and he "tear[s] up." A hustler driver, he stated, has to use both arms because the steering wheel is large and some of the trucks do not have power steering or are hard to turn even with power steering. The last time he drove a truck without power steering was sometime in 2004, but it was not a hustler. In the past three years, he stated that he has not driven a hustler for the Employer that, to his knowledge, did not have power steering, but he drove one for a different employer that did not have power steering.

The Claimant next testified about his ability to use his arm to do different tasks. He stated that he would have to be having a very good day to try to steer his van with just his right arm. He did not remember ever trying to steer with his right arm alone because of his pain. He stated that he does not even try to help steer with his right arm when steering with his left. He testified that he cannot hold a gallon of milk with his right arm, but he can hold a twelve ounce soda.

In an average day, the Claimant reported, he sits at home and goes to church. He did not remember what time he got up the day before the deposition, but he left home early in the morning without eating breakfast. He reported driving himself to the union hall, which is about ten to fifteen minutes from his house, to "take care of some business" with the union president regarding why his compensation was cut off. He did not remember how long he was at the union hall. He stated that he then went to the place where he had the FCE to pick up some paperwork, but reported that he did not get it. The FCE facility was about five to ten minutes from the union hall. After leaving there, he drove his wife to Dr. Mingione's office for an interview which he was not involved with. He reported that he then went to a 7-Eleven on Cook Boulevard to socialize with a member of his church, but he did not know how long he was there. He stated that he and his wife took the friend to Lowes to pick up a few things and then returned to the 7-Eleven. After that, they returned home and the only time he left the house again was to walk around the block because he wanted exercise and was "a little depressed." He was depressed, he explained, because he has bills to pay and no income. He stated that his only income had been his disability check and he was not getting disability benefits from anywhere else.

When asked about his activities the prior weekend, the Claimant could not recall what he did on Saturday. He knew he went out on Saturday night and thought it was to church, but he was not sure. He stated that he goes to church practically every day. He knew that he was in church all day on Sunday; he went to one in Norfolk and another one in Hampton. He reported that at both services, it was standing room only. He did not hold a prayer book or Bible that day, but if he ever does he is sitting and he holds it in his lap with his left hand.

The Claimant testified that he has memory problems, but denied having memory problems before his injury. He stated that his hard hat stayed on his head and was not cracked after the lashing rod hit him on the head.

The Claimant testified that he has not inquired about any jobs because "[w]ouldn't nobody hire me," but stated that he had not contacted any employers to ask for a job. He reported that he "tell[s] everybody I wish I can work," including his coworkers at the union hall and people at church. He stated that he could have had a job pressure washing a 7-Eleven the day before, but he could not do the work. He reported that his wife had asked his friend for the job and his friend stopped by and said "I wish you weren't in the position you was in. . . . Because I could give you a job." The Claimant stated that he could not do the pressure washing job because the gun uses a lot of force and you have to use two hands.

The Claimant confirmed that he started working as a longshoreman full-time in 1995. He reported that before he was a longshoreman, he drove a dump truck for about a year, but he did not know exact dates. He stated that he did not have any problems with the job. He reported that he also drove a trash truck for almost a year; he guessed that was in 1993, but was not sure. He did not have any problems driving or lifting cans, but he was in good shape then. He stated that as a trash truck driver, he had to learn routes, but "[y]ou run it long enough, you'll learn it. I had a helper . . . that was there before I did. He helped me." The Claimant also did roofing work before he drove any of the trucks and was a custodian for the Norfolk City School Board.

The Claimant did not know what third-party litigation was, but his counsel confirmed that the Claimant was being represented by someone else at his firm and had not had any depositions or independent medical evaluations for that case yet.

Employer's § 8(f) Application (EX 52)

EX 52 is a copy of the Employer's application for § 8(f) relief, dated December 27, 2005, and supporting documentation. The Employer alleged the following as preexisting conditions: chronic back injury; chronic neck injury with headaches and disc protrusion; history of concussions, headaches, and repeated head injury; left knee injury; left shoulder injury; right hand injury with permanent impairment and reduced grip strength; and hypertension.

Deposition of Ms. I. Harwell – December 13, 2005 (EX 55)

Ms. Harwell was deposed on December 13, 2005. On examination by the Claimant's counsel, she testified that she graduated as a registered nurse in 1988 and was in the Navy for six years, in pediatrics and ambulatory surgery. She is still involved with the Navy. After she left active duty in 1994, she was a pediatric nurse at the Children's Hospital of the King's Daughters until approximately 2001, when she began doing case management. She testified that she was employed by General Management Solutions, and had been for thirteen months. Prior to that, she was self-employed for three years. With General Management Solutions, Ms. Harwell was a medical case manager who managed medical services for workers' compensation cases. She was hired by the Employer to manage the Claimant's case and that she currently has about eight cases for the Employer. She stated that Mr. M. Willis, her boss, attended one appointment at Dr. Wardell's office for her because she had a conflict.

Ms. Harwell stated that she does not have specific providers she sends people to for treatment and that the client, insurance company, or a third party chooses providers. She stated that for all the cases she has handled for the Employer, the person has been sent to Mr. Schall at Norfolk Physical Therapy for FCEs, but she did not know why. Ms. Harwell reported that she was not involved with the Claimant's case when Dr. Wardell requested the FCE. She stated that she did not get the file until February of 2005, after the FCE was done, but she did review the results.

Ms. Harwell stated that when she meets with a person, she always tells them who she is, who she represents, what her job is, and asks whether they have an attorney. If they have an attorney, she stated, she has to find out if she needs to correspond with the attorney. She also stated that she leaves it up to the person as to whether they want to talk anymore, and sometimes they do not. She reported that the Claimant talked to her on a regular basis, calling her at work and on the weekends. She said that sometimes she could answer his questions and sometimes she could not.

Ms. Harwell testified that she had been to probably 95% of the appointments the Claimant has had since she picked up his file and that the reports were in his file. Her usual routine was to wait while the person saw the doctor and then she would speak to the doctor when the examination was done. She stated that sometimes she met with Dr. Cohn while the Claimant was there, but she always met with Dr. Wardell after the Claimant was finished because it was his policy that the person be gone before he would meet with her. She reported that she also met

with Dr. Mingione, but she did not meet with Dr. Gerstle. She testified that she has also met with Dr. Mansheim on the same day as the Claimant, but she met with him after the Claimant's appointment was over.

When she met with Dr. Mingione and Dr. Wardell, she never asked them to draft reports separate from their office notes. She stated that she did not even ask Dr. Wardell to give the Claimant a rating because she did not think it was necessary, but he did it on his own. With Dr. Mingione, the only thing she asked him for was a urine drug screen because she thought the Claimant was acting inappropriately and she was concerned about his medication. She reported that the drug screen was negative.

Ms. Harwell testified that she has had a lot of contact with the Claimant since February of 2005. She stated that he had stuttered ever since she met him, although sometimes it was more frequently than other times. She noted a change in his behavior at one point, in that he was sleepy all the time and he acted nervous, which is why she requested the drug screen. Aside from that brief period, she reported that his personality and mental health remained fairly consistent. She also reported that he was always compliant and if he missed an appointment with her, he would call her right away.

Ms. Harwell stated that she did not have anything to do with the appointment where Dr. Mingione discussed the Claimant's driving with him. She stated that all she knew was that the Claimant saw Dr. Mingione sometime in August. Dr. Mingione would not meet with her that same day and she had to schedule another day to meet with him, which she reported happened sometimes. When she met with Dr. Mingione later, he brought up the subject of the Claimant's driving and told her he instructed the Claimant not to drive because of his mental status changes. He also told her that he had diagnosed the Claimant with dementia. She stated that she told Dr. Mingione that she had seen the Claimant driving on August 18 and he told her he would send a letter advising the Claimant not to drive. He also told her he would report the Claimant to the DMV if he found out he was driving. Ms. Harwell was not sure, but she thought this might have been around the same time he requested the drug screen.

When asked her opinion on whether the Claimant's complaints of pain and the ability to move his arm were appropriate, Ms. Harwell responded that she could not say because pain is subjective. She stated that she thought he should have progressed further at this point with respect to arm motion, but she could not judge whether his complaints were appropriate. She also stated that she has never given an opinion to a client as to whether she thinks a person is malingering.

On cross-examination, Ms. Harwell testified that she has spoken with the Claimant's wife. She stated that his wife did not discuss his pain with her, but did discuss his mental status and medication. The Claimant's wife told Ms. Harwell that she noticed changes in the Claimant and that he did not take his Namenda, which was prescribed by Dr. Mingione in July or August. She also told Ms. Harwell she was concerned that the Claimant was distant toward her because of his workers' compensation claim and the money he might get from it, and that he was trying to get her to leave him because of the big settlement he was expecting.

Work History of Workers with Less Seniority than Claimant (EX 64)

EX 64 contains the work history for workers with less seniority than the Claimant, which was compiled by Mr. Parker and which he testified about at the hearing. For the week of December 19-23, 2005, the workers made $2,862.00, for the week of January 9-14, 2006, the workers made $2,072.25, for the week of April 25-30, 2006, the workers made $2,173.50, and for the week of May 22-28, 2006, the workers made $2,889.00.

DISCUSSION

The Parties do not dispute the Claimant's entitlement to disability compensation benefits under the Act prior to August 17, 2005; therefore, only the Claimant's entitlement for the period of August 17, 2005, to the present will be discussed in this Decision and Order.

I. THE CLAIMANT'S ENTITLEMENT TO THE § 20 PRESUMPTIONS

To be entitled to compensation under the Act for an injury, a claimant bears the initial burden of establishing a prima facie case that he suffered an injury and that the injury arose out of and in the course of employment. *U.S. Industries/Federal Sheet Metal, Inc. v. Director, OWCP (Riley)*, 455 U.S. 608 (1982). The claimant is not required to introduce affirmative evidence that his working conditions in fact caused his injury; however, he must at least show that working conditions existed which could have caused the harm suffered. *Kelaita v. Triple A Machine Shop*, 13 BRBS 326, 330-31 (1981). Once the claimant has established a prima facie case, § 20 of the Act provides him with the presumptions that his injury is work-related and comes within the provisions of the Act, and that sufficient notice of the claim has been given. 33 U.S.C. § 920(a)-(b) (2000); *Damiano v. Global Terminal & Container Serv.*, 32 BRBS 261, 262 (1998).

Once the claimant has established his prima facie case and is entitled to the § 20(a) presumption, the employer bears the burden to rebut the presumption with "substantial countervailing evidence" that the injury was not caused or aggravated by the claimant's employment. *Swinton v. J. Frank Kelly, Inc*., 554 F.2d 1075, 4 BRBS 466, 474-75 (D.C. Cir. 1976), *cert denied* 429 U.S. 820 (1976). The "substantial evidence" standard requires the employer to present evidence that is "specific and comprehensive enough to sever the potential connection between a particular injury and a job-related event." *Id.* at 478. Speculation and hypothetical probabilities are not enough. *Id.* at 481 (*quoting Steele v. Adler*, 269 F.Supp. 376, 379 (D.D.C. 1967)). Moreover, the employer cannot rebut the presumption by merely suggesting other theories of causation. *Williams v. Chevron, U.S.A.*, 12 BRBS 95, 98 (1980). If the employer successfully rebuts the presumption, the record as a whole must be evaluated to determine causation. *Del Vecchio v. Bowers*, 296 U.S. 280, 286-87 (1935). However, if the employer does not rebut the presumption, "causation is established as a matter of law." *Cairns v. Matson Terminals, Inc.*, 21 BRBS 252, 256 (1988).

A. The Claimant's Right Shoulder

Here, the Claimant has established, by stipulation, that he suffered a right shoulder injury on July 7, 2004, and that conditions existed at work on July 7, 2004, that could have caused the right

shoulder injury. The parties have also stipulated that the injury arose out of and in the course of the Claimant's employment with the Employer and that the Claimant's claim was timely. Therefore, the Claimant is entitled to the presumptions contained in 33 U.S.C. § 920 with respect to his right shoulder injury.

B. The Claimant's Cervical Spine

In addition to his right shoulder injury, the Claimant has alleged a cervical spine injury that arose out of and in the course of employment. Although neck pain is not mentioned in the hospital records from the date of injury, on July 12, 2004, Dr. Wardell, the first physician the Claimant saw after going to the emergency room on the date of injury, diagnosed the Claimant with a cervical spine sprain after thorough examination. Dr. Wardell also opined that the cervical spine injury was caused by the Claimant's work accident on July 7, 2004. (CX 1 at 34.) Additionally, the Claimant has established that working conditions existed on July 7, 2004, that could have caused a cervical spine injury, namely a lashing rod falling on his head and shoulder. Therefore, the Claimant has established a prima facie case that his cervical spine injury arose out of and in the course of his employment with the Employer.

To rebut the Claimant's prima facie case, the Employer has alleged that the Claimant did not report his cervical spine injury at the emergency room the day of his injury, nor did he claim a cervical spine injury on any of his injury reports or his LS-203. This alone is not "substantial countervailing evidence" that the injury was not caused or aggravated by the Claimant's employment. The Board has held that a claimant does not have to allege the specific injury he is seeking benefits for in his initial injury reports for that claim to be considered. *Dangerfield v. Todd Pacific Shipyards, Corp.*, 22 BRBS 104, 107 (1989). The only other evidence in the record to rebut the presumption is that the Claimant sustained a cervical spine sprain in 1997 as the result of a motor vehicle accident. (CX 48.) However, this is also not substantial evidence; if anything, it supports the conclusion that the Claimant's work accident could have aggravated his cervical spine. Since the Employer has presented no evidence to rebut the Claimant's prima facie case, this Administrative Law Judge finds that the Claimant has established entitlement to the presumptions contained in 33 U.S.C. § 920 with respect to his cervical spine injury.

II. THE CLAIMANT WAS TEMPORARILY DISABLED FROM THE DATE OF INJURY UNTIL OCTOBER 19, 2005.

A disability is classified at any given time as either temporary or permanent in nature. *See* 33 U.S.C. § 908. There are two tests for determining the nature of a disability. *Eckley v. Fibrex and Shipping Inc.*, 21 BRBS 120, 122 (1988). First, an employee is permanently disabled if he reaches maximum medical improvement and still has some residual disability. *Id.*; *James v. Pate Stevedoring Co*., 22 BRBS 271 (1989). Second, even if maximum medical improvement has not yet been reached, "an employee [is] permanently disabled when his condition has continued for a lengthy period, and it appears to be of lasting or indefinite duration, as distinguished from one in which recovery merely awaits a normal healing period." *Newport News Shipbuilding and Dry Dock Co. v. Director, OWCP (Chappell)*, 592 F.2d 762, 764, 10 BRBS 81, 83 (4th Cir. 1979) (quoting *Watson v. Gulf Stevedore Corp.*, 400 F.2d 649, 654 (5th Cir. 1968)). If neither of these tests is met, the claimant is temporarily disabled, rather than permanently disabled. The point at

which a claimant's condition changes from temporary to permanent disability is based on the medical evidence, in particular the claimant's date of maximum medical improvement, not economic factors. *Trask v. Lockheed Shipbuilding and Construction Co.*, 17 BRBS 56, 61 (1985).

The Claimant argues that he was temporarily disabled until August 17, 2005, when he became permanently disabled. Based on the medical evidence of record, the Claimant has been given two different maximum medical improvement dates. At the end of July of 2005, Dr. Wardell opined that the Claimant had likely reached maximum medical improvement and recommended an FCE. (CX 16; EX 11.) On August 18, 2005, there is a notation in Dr. Wardell's office notes that he gave an impairment rating, but there is no other information. (CX 16; EX 11.) He also testified at his deposition that the Claimant was nearing maximum medical improvement in late July of 2005 and that he believed the Claimant was at maximum medical improvement in the late summer of 2005. (CX 1 at 33.) However, he did not give a concrete opinion that the Claimant had reached maximum medical improvement, assign an impairment rating, and release the Claimant to sedentary work until October 19, 2005. (CX 16.) Dr. Cohn, on the other hand, opined that the Claimant reached maximum medical improvement on August 17, 2005, but did not give an impairment rating for the right shoulder or release the Claimant to work until November 30, 2005. (CX 10; EX 28.) As Dr. Wardell performed both of the Claimant's surgeries and examined the Claimant a number of times as the treating physician, his assessment of maximum medical improvement bears more weight than Dr. Cohn's. Therefore, the Claimant reached maximum medical improvement on October 19, 2005, and the Claimant's disability became permanent on that date.

III. THE CLAIMANT WAS TOTALLY DISABLED UNTIL NOVEMBER 30, 2005, AND NOT DISABLED THEREAFTER.

The Act defines "disability" as "incapacity because of injury to earn the wages which the employee was receiving at the time of injury in the same or any other employment." 33 U.S.C. § 902(10) (2000). This disability may be either partial or total. *See* 33 U.S.C. § 908 (2000). To be awarded total disability benefits, a claimant must first demonstrate his inability to return to his former job because of his work-related injury. *See v. Wash. Metro. Area Transit Auth.*, 36 F.3d 375, 380 (4th Cir. 1994). To determine whether the claimant can return to his former job, the administrative law judge should compare the claimant's work restrictions with the requirements of his usual employment. *Curit v. Bath Iron Works Corp.*, 22 BRBS 100, 103 (1988). A claimant's usual employment is the regular duties he was performing at the time of his injury. *See Ramirez v. Vessel Jeanne Lou, Inc.*, 14 BRBS 689, 693 (1982). In this case, the Claimant's usual employment, based on his work records was as a longshoremen, specifically a general longshoreman, lasher, and, albeit somewhat less frequently, hustler driver. (CX 14; EX 62.) He was also a slinger a few times. (CX 14; EX 62.)

"A claimant's credible complaints of pain alone may be enough to meet [the] burden" of establishing his inability to return to his usual employment. *Anderson v. Todd Shipyards Corp.*, 22 BRBS 20, 22 (1989). However, as the credibility of a witness is solely for the trier of fact to determine, the administrative law judge may find the claimant's complaints incredible and exaggerated based on inconsistencies in testimony. *Peterson v. Wash. Metro. Area Transit*

Auth., 13 BRBS 891, 896 (1981). Further, the administrative law judge may discredit the opinions of physicians who relied on the claimant's discredited subjective complaints. *Director, OWCP v. Bethlehem Steel Corp.*, 620 F.2d 60, 12 BRBS 344 at 347-48 (5th Cir. 1980), aff'g 8 BRBS 775 (1978). If the claimant establishes his prima facie case, the burden shifts to the employer to demonstrate the availability of suitable alternative employment for the claimant. *See*, 36 F.3d at 380.; *Newport News Shipbuilding and Dry Dock Co. v. Director, OWCP (Chappell)*, 592 F.2d 762, 765, 10 BRBS 81, 83 (4th Cir. 1979).

In this case, the Claimant's subjective complaints with regard to his pain and inability to work and function were inconsistent with objective evidence and his testimony at the hearing and at his prior deposition. For example, the Claimant refused to move his arm more than twenty degrees during examination by Dr. Cohn on August 17, 2005,[21] because of pain, but he testified at the hearing that he did not think he told Dr. Cohn he could only move his arm twenty degrees, even if he was in a lot of pain. (TR at 81.) Dr. Cohn also noted in his September 22, 2005, report after viewing the surveillance video of August 8-9, 2005, that the Claimant seemed much more comfortable using his right arm than he had been when Dr. Cohn examined him a week later. (CX 10; EX 40.)

At his September 8, 2005, FCE, the Claimant gave sub-maximal effort and Mr. Schall opined that the Claimant's subjective complaints of pain and limited functioning were unreliable when compared to objective test results. (EX 30.) He was unable to get accurate measurements to assess the Claimant's functioning because the Claimant did not complete the testing because of complaints of pain, but he could not find any physical reason for the Claimant's complaints. (EX 30.) Additionally, after review of the first surveillance video, which was taken only a month before the FCE, Mr. Schall noted that the Claimant used his right arm many times without showing signs of dysfunction, "in marked contrast to the FCE where he presented with the right arm at his side and virtually no active usage of it." (EX 31.) Moreover, Mr. Schall observed on more than one occasion that the Claimant was able to move his right arm and shoulder normally and without pain when distracted. (EX 31, 53.)

It is also noteworthy that no physician found signs of atrophy in the Claimant's right arm or shoulder. (CX 7, 10; EX 27, 28.) Dr. Cohn testified at his September 22, 2006, deposition that lack of atrophy indicates that the person is using the extremity as much as the other and has good strength. (CX 3 at 35; EX 57 at 35.) Moreover, Dr. Pellegrino was unable to find any evidence of wasting in the Claimant's right hand. (CX 7; EX 27.) Thus, the Claimant's complaints that he is unable to use his arm much are not credible.

The surveillance video evidence also shows that the Claimant's ability to move his right arm was different than what he represented to physicians and physical therapist. Drs. Cohn and Ross both opined after viewing the videos that they could not tell just from the videos that the Claimant's right arm was injured. (CX 10; EX 60, 67.) Dr. Cohn also stated at his November 29, 2005, deposition that the Claimant's actions on the surveillance video were significantly different than what the Claimant told him he could do. (CX 5 at 25; EX 42 at 25.) Dr. Ross further stated that the Claimant's use of his arm on the videos was markedly different than what the Claimant told him at the examination and what Dr. Ross observed. (EX 67.) As noted above, Mr. Schall also

[21] CX 10; EX 28.

reported that the Claimant's use of his right arm on the first surveillance video was very different than what he presented at his FCE. (EX 31.)

There are other inconsistencies in the Claimant's testimony that call into question his veracity. He repeatedly testified that he wanted to work and would take jobs, but no one offered him anything. (TR at 44, 57.) He testified that he signed up for jobs between January 19, 2006, and March 22, 2006, but no one would take him because they knew he could not do the work. (TR at 54-55.) He also testified that no one would hire him because "it went around" that he was unable to do the jobs and that "someone" told the union representative he could not do the jobs. (TR at 44.) However, he later admitted that he told the union representative that he could not do certain jobs. (TR at 56.)

The Claimant's testimony regarding his education was also inconsistent. At the hearing, he admitted that he had lied during his deposition when he said he had only gone to school through second or third grade, because it was too embarrassing to let people know he had been in a junior high school. (TR at 39, 60.) He told Dr. Mansheim he left school in first grade. (EX 33.) Additionally, although he denied doing so at the hearing, Dr. Gerstle's records show he told the physician he had graduated from high school. (TR at 60-61; CX 2 at 26-27.)

Based on all the evidence in the record, this Administrative Law Judge finds that the Claimant's complaints of pain and inability to work are not credible.

As the Claimant's complaints are not credible, the opinions of the Claimant's physicians, Dr. Wardell and Dr. Mingione, regarding the Claimant's work restrictions and ability to work are given little weight since they relied heavily on the Claimant's subjective complaints in reaching their opinions. Additionally, Dr. Wardell did not view either surveillance video and Dr. Mingione only viewed the first surveillance video.

The Claimant's treating orthopedist, Dr. Wardell, opined that the Claimant was totally disabled on three different occasions. The first time was December 2, 2005, when he stated the Claimant was totally disabled because of his pain medication. (CX 16.) However, he pointed to no findings to support that conclusion and the note of December 16, 2005, from his physician's assistant shows that the Claimant was released to work at that time. The second time was January 11, 2006, although he again pointed to nothing to support his opinion; in fact, the only thing the note stated was that the Claimant had been in the office and he was totally disabled. (CX 16.) However, Dr. Wardell noted in his office notes from that day that the Claimant reported feeling better, which contradicts his finding that he was totally disabled. (CX 16.)

The third time Dr. Wardell opined that the Claimant was totally disabled was May 17, 2006, when he reported that the Claimant could not work because of limited motion, weakness, and pain in his right shoulder, and because of his narcotic pain medications. (CX 1 at CXD 10.) He testified at his deposition that this was his final opinion. (CX 1 at 86.) However, he admitted that he relied heavily on the Claimant's subjective complaints when giving his opinions, particularly his opinions regarding the Claimant's ability to work. (CX 1 at 93.) Moreover, there is no evidence that the Claimant was impaired by pain medications, except for his complaint that it made him tired. (TR at 47; CX 4 at 25; EX 65 at 25.) Dr. Wardell also

admitted that, based only on the objective results of the Claimant's second rotator cuff surgery, the Claimant should be able to perform some longshore jobs. (CX 1 at 83.) Further, he admitted he had no objective tests showing that the second surgery was unsuccessful and he could not explain why either surgery did not help. (CX 1 at 51, 64, 83.)

Dr. Wardell's opinions are also called into question because of the strange note written by his physician's assistant on December 16, 2005. Dr. Wardell testified that he agreed with the "spirit" of the note, although he could not explain why the it had been given at that time, as he had not restricted the Claimant from using his arm at work before and did not know of a time when the Claimant had overexerted his shoulder at work. (CX 1 at 68-75.) None of the other physicians who had read the note and examined the Claimant could explain why the Claimant would be restricted from using his arm at work but be encouraged to use it at home. In fact, they all agreed that they would allow the Claimant to use his arm at work in the same manner he uses it at home. (CX 2 at 29-30; CX 3 at 50; EX 57 at 50.)

Dr. Mingione admitted at his deposition that he could only assess the Claimant based on his subjective complaints. (CX 2 at 10.) He could not give an explanation from a psychiatric or pain management perspective as to why the Claimant's pain was inconsistent. (CX 2 at 29.) Moreover, he could not give an adequate explanation as to why the Claimant's confusion and dementia "surprisingly" disappeared. (CX 2 at 24.) He also refused to entertain the idea that the Claimant was not depressed, even though he admitted the antidepressants he had prescribed were not working. (CX 2 at 24-25.) His explanation as to why the medication was not working was that the Claimant's "depression is so much based on reality . . . and antidepressants don't change external reality." (CX 2 at 25.) Dr. Mingione also testified that he did not think the Claimant was bright enough to malinger, but admitted patients have fooled him in the past. (CX 2 at 11, 30.) It is noteworthy that he stopped prescribing the Claimant oxycodone in May of 2006 and confirmed that on September 26, 2006, yet just over a month later, and only a week before the hearing, he suddenly prescribed oxycodone again. (CX 2 at 24; CX 9; CX 18.)

Likewise, Dr. Gerstle's opinions that the Claimant had a cognitive disorder, that he suffered a traumatic brain injury, and that his intellectual functioning was in the mentally deficient range are given no weight. Dr. Gerstle appeared to be under the mistaken impression that the Claimant was a high school graduate, and as such, he gave the Claimant tests that were inappropriate for someone of the Claimant's limited education. (CX 8; EX 25-26; EX 65 at 15-16.) The Claimant denied telling Dr. Gerstle he had graduated from high school, but the record shows that there is no other way the physician could have gotten that information. (TR at 60-61; CX 2 at 26-27.)

Dr. Cohn, Dr. Mansheim, and Dr. Ross, on the other hand, have given more well-reasoned opinions regarding the Claimant's work restrictions and his ability to work. Each of these physicians had the opportunity to perform examinations, review the Claimant's medical records, and view both surveillance videos. None of these physicians have discounted the Claimant's complaints of pain, but they all opined that the Claimant's ability to work and function is greater than what he presented when they compared objective findings to subjective complaints. (EX 67; CX 4 at 20, 58-59; EX 65 at 20, 58-59.)

Dr. Cohn examined the Claimant three times after the Claimant's second rotator cuff surgery and four times in total. (CX 10; EX 19, 28, 40, 41, 43, and 60.) After examination on August 17, 2005, Dr. Cohn opined that the Claimant was at maximum medical improvement, needed no more orthopedic treatment, and could not return to longshore work because of pain complaints and "psychological overlay." (CX 10; EX 28.) However, he could not connect the Claimant's complaints and psychological issues to his work-related injury. (CX 10; EX 28.) He did testify at his November 29, 2005, deposition that he could not examine the Claimant well enough on August 17 to determine his level of functioning, so his opinions at that time were based on the Claimant's subjective complaints. (CX 5 at 17-18. 24; EX 42 at 17-18, 24.)

Once Dr. Cohn had the opportunity to review other objective evidence, however, he based his opinions on those findings rather than the Claimant's subjective complaints. On November 30, 2005, Dr. Cohn reexamined the Claimant and, based on his findings at that and prior examinations and the Claimant's medical records, he determined that the Claimant could work as a general longshoreman, as well as a groundsman, winchman, and slinger. (CX 10; EX 41.) He also gave the Claimant work restrictions and restricted him from driving at work until an FCE could be obtained to answer the question of whether he could drive a hustler. (CX 10; EX 41.) However, he did note that, based on objective evidence alone, the Claimant should be able to drive a hustler at that point. (CX 10; EX 41.) On December 5, 2005, Dr. Cohn opined that, based on objective factors, such as the surveillance video, rather than the Claimant's subjective complaints, the Claimant could drive a hustler. (CX 10; EX 43.) On March 22, 2006, Dr. Cohn again opined that the Claimant could drive a hustler. (CX 10; EX 60.) In that same report, he opined that the Claimant's work restrictions should be based on objective findings rather than subjective complaints because of the Claimant's inconsistent behavior. (CX 10; EX 60.) The only work restriction he recommended at that time was for over-the-shoulder use of the right arm. (CX 10; EX 60.) He later testified at his September 22, 2006, deposition that after his review of the second surveillance video on March 22, 2006, he would still approve the jobs he had previously approved, including hustler driver. (CX 3 at 52, 108; EX 57 at 52, 108.)

Unlike Dr. Mingione or Dr. Gerstle, Dr. Mansheim evaluated the Claimant knowing he was not a high school graduate and in fact had limited education. Based on his testing and review of other physicians' evaluations, he determined that the Claimant did not have depression, dementia, as Dr. Mingione diagnosed, or any cognitive impairment or psychiatric condition resulting from his work-related injury. (EX 33, 58.) Dr. Pellegrino also agreed that the Claimant did not have a cognitive impairment related to his work injury. (EX 37.) Further, Dr. Mansheim could find no indication that the Claimant had cognitive problems related to pain medication which would cause him to be unable to work within his medical restrictions and qualifications, as his mental abilities were not impaired the day he tested positive for oxycodone. (CX 4 at 25; EX 44, EX 65 at 25.) He opined that, in determining the Claimant's ability to work, he would base the decision on objective evidence of functioning, not subjective complaints. (CX 4 at 26; EX 65 at 26.)

Dr. Mansheim also determined that the Claimant was not mentally retarded, but was functionally illiterate and did not have the adaptive deficits associated with mental retardation. (EX 33, 65 at 14-15.) He disagreed with Dr. Mingione's opinion that the Claimant was not bright enough to malinger because he found the Claimant to be very bright when they met and stated that the

Claimant had to have some intelligence to be able to function as he does, but that he was just not very verbal. (CX 4 at 54; EX 65 at 54.)

When Dr. Ross examined the Claimant on October 20, 2006, he found that the Claimant had good muscle definition in both arms. (EX 67.) Dr. Ross noted that the Claimant had a "high degree of self-perceived disability." (EX 67.) After watching the surveillance tapes, he stated that he would not even know which shoulder was injured just from the videos. (EX 67.) He also stated that the Claimant's presentation was much different than what he saw on the video. (EX 67.) It was Dr. Ross's opinion that the Claimant's functional impairment is less than he claims, although he may have discomfort. (EX 67.) Dr. Ross released the Claimant to work as a hustler driver, a general longshoreman, slinger, winchman, and light duty painter/power washer, as long as someone could assist in lifting for the light duty job. (EX 67.) Thus, although Dr. Ross did give the Claimant an upper extremity impairment rating of 10%, that impairment does not impact the Claimant's ability to return to his usual employment.

After consideration of all the evidence, this Administrative Law Judge finds that the Claimant cannot return to work as a lasher. Additionally, this Administrative Law Judge finds that he cannot perform the light duty painter/power washer job. Dr. Cohn testified that he disapproved the light duty painter/power washer job on June 1, 2006. (CX 3 at 99-100; EX 57 at 99-100.) Dr. Ross was the only physician to approve the job, but he even expressed reservations about it because of the lifting requirement. (EX 67.) It is true that Mr. Parker testified he recently changed the job description to reflect a twenty pound lifting requirement rather than the previous fifty-six pound lifting requirement. (TR at 101.) However, no physician has approved that job description as amended. Moreover, Dr. Cohn had also previously restricted the Claimant from over-the-shoulder work and it does not appear that the restriction has been lifted. Thus, since the Claimant is restricted from over-the-shoulder work, he cannot perform a job where intermittent reaching over-the-shoulder for up to two hours per day is a requirement.

This Administrative Law Judge does find, however, that the Claimant can perform his other usual longshore jobs of general longshoreman, slinger, and hustler driver. None of these jobs require the Claimant to work above shoulder level. Dr. Cohn released the Claimant to the first two jobs on November 30, 2005, and the latter on December 5, 2005, after reviewing the surveillance video and other objective evidence. He still allowed the Claimant to work as a general longshoreman and slinger on October 30, 2006, based on the amended job descriptions. Moreover, Dr. Ross also approved the amended job descriptions.

The Claimant also alleges he sustained a cervical spine injury which has contributed to his permanent total disability. However, he has presented no evidence that he has been given work restrictions because of that cervical spine injury and has offered no evidence that his cervical spine injury has caused him to be unable to return to his usual employment. Therefore, this Administrative Law Judge finds that the Claimant's cervical spine injury is not compensable. Additionally, even if the Claimant suffers from depression, there is no credible evidence that he has any work restrictions because of that alleged depression or any other psychological problems that are preventing him from returning to his usual employment.

Although the Claimant was released to sedentary work by Dr. Wardell on October 19, 2005, the Employer has presented no evidence that there was suitable sedentary work available to the Claimant at that time. Thus, the Claimant remained totally disabled until he was released to his usual employment by Dr. Cohn. Accordingly, the Claimant is not currently disabled and is not entitled to disability compensation benefits beyond November 30, 2005.

III. THE CLAIMANT IS ENTITLED TO SOME CONTINUED MEDICAL BENEFITS AND REIMBURSEMENT.

An employer is responsible for the claimant's reasonable and necessary medical expenses for the treatment of a work-related injury. 33 U.S.C. § 907(a) (2000); *Colburn v. General Dynamics Corp.*, 21 BRBS 219, 222 (1988). This responsibility includes reimbursing the claimant for out-of-pocket medical expenses, as long as the claimant has complied with 33 U.S.C. § 907(d)(1), which states that:

> [a]n employee shall not be entitled to recover any amount expended by him for medical or other treatment or services unless-- (A) the employer shall have refused or neglected a request to furnish such services and the employee has complied with subsections (b) and (c) of this section and the applicable regulations; or (B) the nature of the injury required such treatment and services and the employer or his superintendent or foreman having knowledge of such injury shall have neglected to provide or authorize same.

33 U.S.C. § 907(d)(1); *Mattox v. Sun Shipbuilding and Dry Dock Co.*, 15 BRBS 162, 171-172 (1982). However, even if the employer refuses to authorize or provide medical care, the claimant is not entitled to reimbursement unless "the treatment he subsequently procures was necessary for treatment of the injury." *Rieche v. Tracor Marine, Inc.*, 16 BRBS 272, 275 (1984). It is the claimant's burden to show medical treatment was necessary. *Schoen v. U.S. Chamber of Commerce*, 30 BRBS 112, 114 (1996). The claimant can establish a prima facie case for payment of medical expenses where a physician "indicates treatment was necessary for a work-related condition." *Turner v. Chesapeake & Potomac Tel. Co.*, 16 BRBS 255, 257-58 (1984).

On May 17, 2006, the Employer controverted the Claimant's right to future medical benefits because of his alleged misrepresentations to his doctors. (CX 15.7) On August 17, 2005, Dr. Cohn opined that the Claimant did not need any further orthopedic treatment for his work-related right shoulder injury. (CX 10; EX 28.) Dr. Cohn also testified at his September 22, 2006, deposition that he would not recommend another surgery because the Claimant had not been cleared by pain management and he was not convinced the Claimant's pain was organic and related to his shoulder. (CX 3 at 77-78; EX 57 at 77-78.) Moreover, there is no evidence in the record that any other physician has opined that the Claimant needs more orthopedic treatment. Therefore, any orthopedic treatment beyond August 17, 2005, is unnecessary and the Claimant is not entitled to reimbursement for orthopedic treatment or any related future medical expenses.

At his deposition, Dr. Mingione opined that the Claimant would need to remain in treatment with him until a comfortable lifestyle could be established with respect to a job. (CX 2 at 12.) On January 20, 2006, Dr. Mansheim opined that Dr. Mingione's treatment was reasonable and

necessary because "it is not unreasonable for [the Claimant] to see a doctor for once monthly brief medication management visits in order to have treatment for pain." (EX 58.) The Employer has offered no other evidence in opposition to Dr. Mansheim's opinion. Therefore, the Claimant is entitled to future medical benefits and reimbursement relating to reasonable and necessary treatment by Dr. Mingione for pain medication management.

The Claimant has also been receiving injections from Dr. Wardell for pain management. Dr. Wardell opined that the Claimant would need to continue receiving injections to reduce his reliance on narcotic pain medication. (CX 16.) However, he testified that the only evidence he had that the injections were reducing the Claimant's reliance on narcotics was the Claimant's report that he was taking less. (CX 1 at 53.) He further testified that he continued to give the Claimant injections, even though he had not spoken to Dr. Mingione about their success since February of 2006. (CX 1 at 53-54.) Based on this evidence, it is unclear whether the injections are reasonable and necessary, as Dr. Wardell does not even know if they are serving their purpose. Therefore, this Administrative Law Judge finds that the Claimant is not entitled to reimbursement for injections by Dr. Wardell.

IV. SUSPENSION OF BENEFITS PURSUANT TO § 7(d)(4) OF THE ACT.

The Employer alleges that the Claimant's benefits should be suspended as of January 18, 2005, pursuant to § 7(d)(4) of the Act because the Claimant did not give full effort during his FCEs and Dr. Cohn's examinations. (Empl. Br. at 54.) Section 7(d)(4) of the Act provides that if the claimant "unreasonably refuses to submit to medical or surgical treatment," payment of compensation may be suspended during such time the refusal continues, unless the refusal was justified. 33 U.S.C. § 907(d)(4). The suspension may not be applied retroactively and does not apply prior to the employer raising the issue. *Dodd v. Newport News Shipbuilding and Dry Dock Co.*, 22 BRBS 245, 249 (1989). Moreover, medical benefits cannot be denied pursuant to § 7(d)(4) of the Act because the Board has held that the definition of "compensation" does not include medical benefits. *Dodd v. Crown Central Petroleum Corp.*, 36 BRBS 85, 90 n. 6 (2002); *Aurelio v. Louisiana Stevedores, Inc.*, 22 BRBS 418, 423 (1989) and cases cited therein. It appears from the record that the Employer first raised this issue at the January 18, 2006, informal conference. (ALJX 9.) As such, that is the earliest date from which the Claimant's benefits could be suspended. Based on the findings above, the Claimant was not entitled to disability compensation at that time and medical benefits cannot be suspended; therefore, the issue is moot.

V. THE EMPLOYER IS NOT ENTITLED TO SPECIAL FUND RELIEF PURSUANT TO § 8(f) OF THE ACT.

When an claimant becomes permanently and totally disabled, his employer will only be responsible for 104 weeks of disability benefits if he had a pre-existing permanent partial disability that contributed to his permanent total disability. 33 U.S.C. § 908(f)(1) (2000); *Director, OWCP v. Newport News Shipbuilding and Dry Dock Co. (Langley)*, 676 F.2d 110, 112 (4th Cir. 1982). The remainder of the claimant's disability benefits will be paid out of a special fund set up under 33 U.S.C. § 944. 33 U.S.C. § 908(f)(2)(A). However, before the employer is entitled to § 8(f) relief, it must establish: (1) a pre-existing permanent partial disability; (2) that the disability was manifest to the employer; and (3) that the preexisting disability "combine[d]

with the subsequent disability and contribute[d] to the resulting permanent total disability." *Langley*, 676 F.2d at 114. Here, the Employer has not established that a preexisting permanent partial disability combined with the Claimant's shoulder injury, contributing to his permanent total disability such that Special Fund relief is available. The Employer also conceded in the post-hearing brief that the current medical evidence does not support its § 8(f) application. Accordingly, the Employer is not entitled to Special Fund relief pursuant to 33 U.S.C. § 908(f).

CONCLUSION AND FINDINGS OF FACT

After deliberation on all the evidence of record, including post-hearing briefs of counsel, this Administrative Law judge finds:

1. The Claimant suffered a right shoulder injury on July 7, 2004, arising out of and in the course of his employment with the Employer.

2. The Claimant established a prima facie case that his cervical spine injury arose out of and in the course of his employment as a longshoreman with the Employer on July 7, 2004, invoking the 33 U.S.C. § 920(a) presumption that his cervical spine injury is work-related.

3. The Claimant gave timely notice of his claim and the Employer timely controverted.

4. The Claimant's cervical spine injury is not compensable under the Act.

5. The Claimant's average weekly wage on July 7, 2004, was $1,514.55, with a compensation rate of $1,009.70.

6. The Claimant was paid temporary total disability benefits from July 7, 2004, to February 14, 2005, inclusive, and March 1, 2005, to October 19, 2005, inclusive, for a total of $65,774.73 in temporary total disability benefits.

7. The Claimant was paid temporary partial disability benefits from February 15, 2005, to February 28, 2005, inclusive, for a total of $188.37 in temporary partial disability benefits.

8. The Claimant is entitled to temporary total disability benefits from August 17, 2005 through October 19, 2005, inclusive, at a compensation rate of $1,009.70

9. The Claimant is entitled to permanent total disability benefits from October 20, 2005, to November 30, 2005, inclusive, at a compensation rate of $1,009.70.

10. The Claimant has not been disabled and entitled to disability compensation within the meaning of the Act since December 1, 2005

11. The Employer is responsible for future medical expenses and reimbursement for the Claimant's reasonable and necessary treatment by Dr. Mingione for pain medication management for his work-related right shoulder injury.

12. The Claimant's entitlement to disability compensation benefits may not suspended pursuant to 33 U.S.C. § 907(d)(4).

13. The Employer is not entitled to Special Fund relief pursuant to 33 U.S.C. § 908(f).

ORDER

It is hereby **ORDERED** that:

1. In accordance with the Act, the Employer, Ceres Marine Terminals, Inc., shall pay compensation to the Claimant at a rate of $1,009.70 per week for the following periods:

    a. temporary total disability compensation from August 17, 2005, to October 19, 2005, inclusive; and

    b. permanent total disability compensation from October 20, 2005, to November 30, 2005, inclusive.

2. The Employer shall receive credit for any related disability benefits previously overpaid to the Claimant.

3. The Employer shall provide such reasonable, appropriate, and necessary medical treatment as the nature of the Claimant's work-related pain management treatment requires pursuant to 33 U.S.C. § 907.

4. Interest at the rate specified in 28 U.S.C. § 1961 in effect when this Decision and Order is filed with the District Director shall be paid on all accrued benefits computed from the date on which each payment was originally due to be paid.

5. All monetary computations made pursuant to this Order are subject to verification by the District Director.

6. Within twenty (20) days of the receipt of this Decision and Order, Claimant's attorney shall file a fully itemized and supported fee petition with the Court, and send a copy of same to opposing counsel who shall then have fifteen (15) days to respond with objections thereto.

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ALAN L. BERGSTROM
Administrative Law Judge